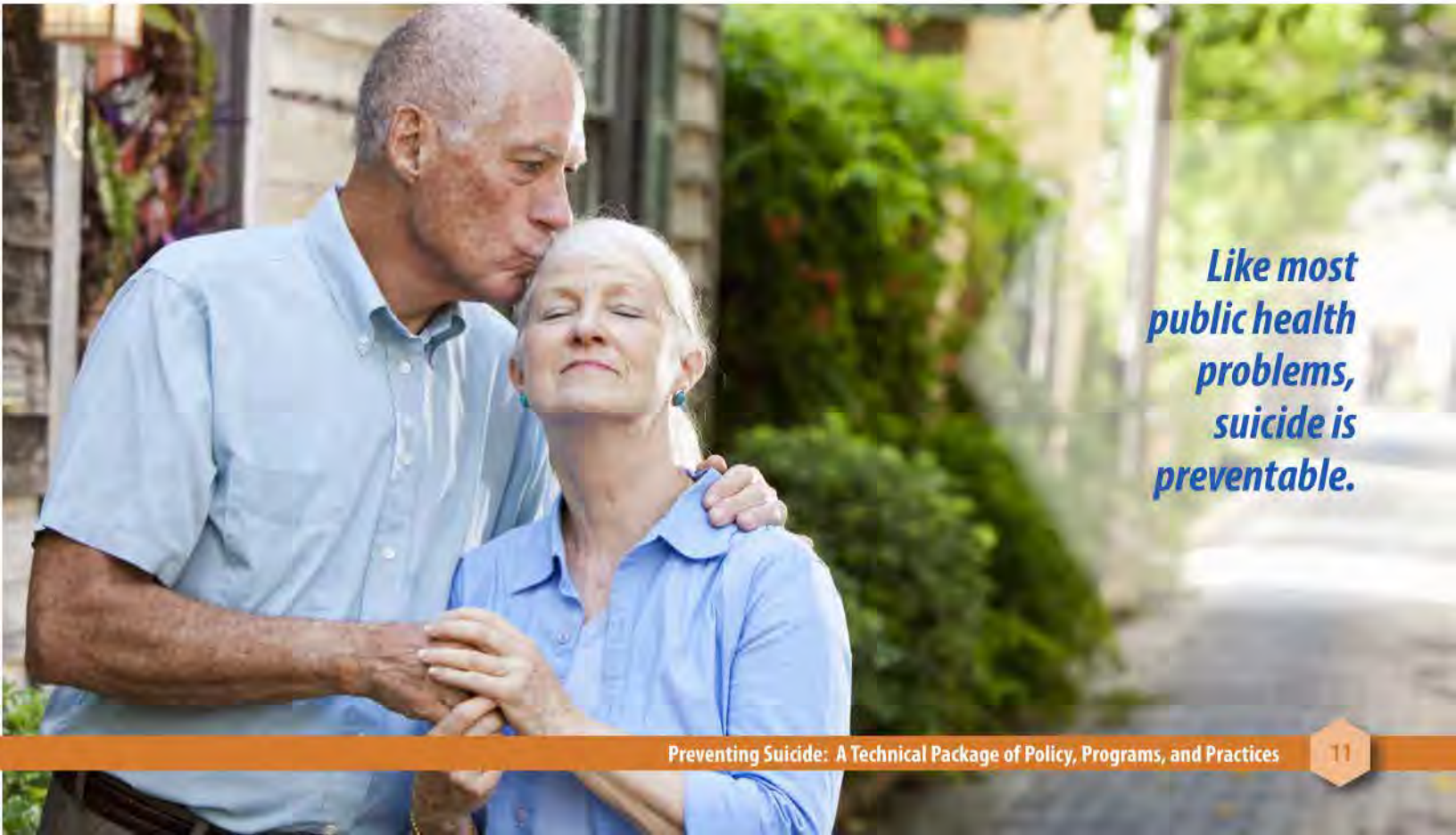
Within this technical package, some approaches do not yet have research evidence demonstrating impact on rates of suicide but instead are supported by evidence indicating impacts on risk or protective factors for suicide (e.g., help-seeking, stigma reduction, depression, connectedness). In terms of the strength of the evidence, programs that have demonstrated effects on suicidal behavior (e.g., reductions in deaths, attempts) provide a higher-level of evidence, but the evidence base is not that strong in all areas. For instance, there has been less evaluation of community engagement and family programs on suicidal behavior. Thus, approaches in this package that have effects on risk or protective factors reflect the developing nature of the evidence base and the use of the best available evidence at a given time.

It is also important to note that there is often significant heterogeneity among the programs, policies, or practices that fall within one approach or strategy in terms of the nature and quality of the available evidence. Not all programs, policies, or practices that utilize the same approach are equally effective, and even those that are effective may not work across all populations. Tailoring programs and conducting more evaluations may be necessary to address different population groups. The evidence-based programs, practices, or policies included in the package are not intended to be a comprehensive list for each approach, but rather to serve as examples that have been shown to impact suicide or have beneficial effects on risk or protective factors for suicide.

Contextual and Cross-Cutting Themes

One important feature of the package is the complementary and potentially synergistic impact of the strategies and approaches. The strategies and approaches included in this technical package represent different levels of the social ecology, with efforts intended to impact community and societal levels, as well individual and relationship levels. The strategies and approaches are intended to work in combination and reinforce each other to prevent suicide (see box on page 12). The strategies are arranged in order such that those strategies hypothesized to have the greatest potential for broad public health impact on suicide are included first, followed by those that might impact subsets of the population (e.g., persons who have already made a suicide attempt).



Preventing Suicide

Strategy	Approach
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access and delivery of suicide care	• Coverage of mental health conditions in health insurance policies • Reduce provider shortages in underserved areas • Safer suicide care through systems change
Create protective environments	• Reduce access to lethal means among persons at risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm programs • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning programs • Parenting skill and family relationship programs
Identify and support people at risk	• Gatekeeper training • Crisis intervention • Treatment for people at risk of suicide • Treatment to prevent re-attempts
Lessen harms and prevent future risk	• Postvention • Safe reporting and messaging about suicide

It is important to note that these strategies are not mutually exclusive but each has an immediate focus. For instance, social-emotional learning programs, an approach under the *Teach Coping and Problem-Solving Skills* strategy, sometimes include components to change peer norms and the broader environment. The primary focus of these programs, however, is to provide children and youth with skills to resolve problems in relationships, school, and with peers, and to help youth address other negative influences (e.g., substance use) associated with suicide.

The goal of this package is to stress the importance of comprehensive prevention efforts and to provide examples of effective programs addressing each level of the social ecology, with the knowledge that some programs, practices, and policies may impact multiple levels. Further, those that involve multiple sectors and that impact multiple levels of the social ecology are more likely to have a greater impact on the overall burden of suicide.

Suicide ideation, thoughts, attempts, and deaths vary by gender, race/ethnicity, age, occupation, and other important population characteristics.[6,50] Further, certain transition periods are also associated with higher rates of suicide (e.g., transition from working into retirement, transition from active duty military status to civilian status).[48,51] In fact, suicide risk can change along with dynamic risk factors. For example, individuals' coping skills may change during periods of crisis and heightened stress, limiting their normal ability to effectively solve problems and cope. Research indicates that suicide risk changes as a result of the number and intensity of key risk and protective factors experienced.[52] Ideally, the availability of multiple strategies and approaches tailored to the social, economic, cultural, and environmental context of individuals and communities are desirable as they may increase the likelihood of removing barriers to supportive and effective care and provide opportunities to develop individual and community resilience.[1]

Identifying programs, practices, and policies with evidence of impact on suicide, suicide attempts, or beneficial effects on risk or protective factors for suicide is only the first step. In practice, the effectiveness of the programs, policies and practices identified in this package will be strongly dependent on how well they are implemented, as well as the partners and communities in which they are implemented. Practitioners in the field may be in the best position to assess the needs and strengths of their communities and work with community members to make decisions about the combination of approaches included here that are best suited to their context.

Data-driven strategic planning processes can help communities with this work.[53-55] These planning processes engage and guide community stakeholders through a prevention planning process designed to address a community's profile of risk and protective factors with evidence-based programs, practices, and policies. These processes can also be used to monitor implementation, track outcomes, and make adjustments as indicated by the data. The readiness of the program for broad dissemination and implementation (e.g., availability of program materials, training and technical assistance) can also influence program effects. Implementation guidance to assist practitioners, organizations and communities will be developed separately.

This package includes strategies where public health agencies are well positioned to bring leadership and resources to implementation efforts. It also includes strategies where public health can serve as an important collaborator (e.g., strategies addressing community and societal level risks), but where leadership and commitment from other sectors such as business, labor or health care is critical to implement a particular policy or program (e.g., workplace policies; treatment to prevent re-attempts). The role of various sectors in the implementation of a strategy or approach in preventing suicide is described further in the section on *Sector Involvement*.

In the sections that follow, the strategies and approaches with the best available evidence for preventing suicide are described.



Strengthen Economic Supports

Rationale

Studies from the U.S. examining historical trends indicate that suicide rates increase during economic recessions marked by high unemployment rates, job losses, and economic instability and decrease during economic expansions and periods marked by low unemployment rates, particularly for working-age individuals 25 to 64 years old.[56,57] Economic and financial strain, such as job loss, long periods of unemployment, reduced income, difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress may increase an individual's risk for suicide or may indirectly increase risk by exacerbating related physical and mental health problems.[58] Buffering these risks can, therefore, potentially protect against suicide. For example, strengthening economic support systems can help people stay in their homes or obtain affordable housing while also paying for necessities such as food and medical care, job training, child care, among other expenses required for daily living. In providing this support, stress and anxiety and the potential for a crisis situation may be reduced, thereby preventing suicide. Although more research is needed to understand how economic factors interact with other factors to increase suicide risk, the available evidence suggests that strengthening economic supports may be one opportunity to buffer suicide risk.

Approaches

Economic supports for individuals and families can be strengthened by targeting household financial security and ensuring stability in housing during periods of economic stress.

Strengthening household financial security can potentially buffer the risk of suicide by providing individuals with the financial means to lessen the stress and hardship associated with a job loss or other unanticipated financial problems. The provision of unemployment benefits and other forms of temporary assistance, livable wages, medical benefits, and retirement and disability insurance to help cover the cost of necessities or to offset costs in the event of disability, are examples of ways to strengthen household financial security.

Housing stabilization policies aim to keep people in their homes and provide housing options for those in need during times of financial insecurity. This may occur through programs that provide affordable housing such as through government subsidies or through other options available to potential homebuyers such as loan modification programs, move-out planning, or financial counseling services that help minimize the risk or impact of foreclosures and eviction.

Potential Outcomes

- Reductions in foreclosure rates
- Reductions in eviction rates
- Reductions in emotional distress
- Reductions in rates of suicide

Evidence

There is evidence suggesting that strengthening household financial security and stabilizing housing can reduce suicide risk.



Strengthen household financial security. The *Federal-State Unemployment Insurance Program* allows states to define the maximum amount and duration of unemployment benefits that workers are entitled to receive after a job loss.[59] An examination of variations in *unemployment benefit programs* across states demonstrated that the impact of unemployment on rates of suicide was offset in those states that provided greater than average unemployment benefits (mean level: $7,990 per person in U.S. constant dollars). The effects of *unemployment benefit programs* were also consistent by sex and age group.[59] Another U.S. study examining the link between unemployment and suicide rates using monthly suicide data, length of unemployment (less than 5 weeks, 5-14 weeks, 15-26 weeks, and greater than 26 weeks), and job losses found that the duration of unemployment, as opposed to just the loss of a job, predicted suicide risk.[60] Together, these results suggest that not only should state unemployment benefit programs be generous in their financial allocations, but also in their duration.

Other measures to strengthen household financial security (e.g., transfer payments related to retirement and disability insurance, unemployment insurance compensation, medical benefits, and other forms of family assistance) have also shown an impact on rates of suicide. A study by Flavin and Radcliff[61] examined the impact of states' per capita spending on transfer payments, medical benefits, and family assistance (Temporary Assistance to Needy Families—TANF) and total state spending on suicide rates between 1990-2000, controlling for a number of suicide risk factors (e.g., residential mobility, divorce rate, unemployment rate) at the state level. As per capita spending on total transfer payments, medical benefits, and family assistance increased there was an associated decrease in state suicide rates. In terms of lives saved, Flavin and Radcliff calculated the cost of reducing a state's suicide rate by a full point for the years studied.[61] At the national level, they estimated 3,000 fewer suicides would occur per year nationwide if every state increased its per capita spending on these types of



assistance by $45 per year.[61] Although this was a correlational study, the results demonstrate the potential benefits of policies that reach particularly vulnerable individuals during periods of great need. More evaluation studies are needed to further understand the outcomes impacted by programs such as these.

Housing stabilization policies. The *Neighborhood Stabilization Program*[62] was designed to help neighborhoods suffering from high rates of foreclosure and abandonment by slowing the deterioration of the neighborhoods and providing affordable housing options for low, moderate, and middle-income homebuyers. This program also offers financial assistance to eligible individuals for the purchase of a new home. Although this program has not been rigorously evaluated for its impact on suicide outcomes, it addresses foreclosure and eviction, which are risk factors for suicide. A longitudinal analysis of annual data on suicides and foreclosures demonstrated that as the proportion of foreclosed properties increased in U.S. states, so did the state suicide rate, particularly among working-aged adults.[63] Another study of data from 16 U.S. states participating in the *National Violent Death Reporting System* found that suicides precipitated by home foreclosures and evictions increased more than 100% from 2005 (before the housing crisis began) to 2010 (after it had peaked).[57] Most of these suicides occurred prior to the actual loss of the decedent's home. These findings suggest that integrating suicide prevention resources, messaging, and referrals into financial, foreclosure, and move-out planning and counseling services may help to prevent suicide.



Strengthen Access and Delivery of Suicide Care

Rationale

While most people with mental health problems do not attempt or die by suicide[18,19] and the level of risk conferred by different types of mental illness varies,[64-66] previous research indicates that mental illness is an important risk factor for suicide.[5,67] State-level suicide rates have also been found to be correlated with general mental health measures such as depression.[68,69] Findings from the *National Comorbidity Survey* indicate that relatively few people in the U.S. with mental health disorders receive treatment for those conditions.[70] Lack of access to mental health care is one of the contributing factors related to the underuse of mental health services.[71] Identifying ways to improve access to timely, affordable, and quality mental health and suicide care for people in need is a critical component to prevention.[5] Additionally, research suggests that services provided are maximized when health and behavioral health care systems are set up to effectively and efficiently deliver such care.[72] Apart from treatment benefits, these approaches can also normalize help-seeking behavior and increase the use of such services.

Approaches

There are a number of approaches that can be used to strengthen access and delivery of suicide care, including:

Coverage of mental health conditions in health insurance policies. Federal and state laws include provisions for equal coverage of mental health services in health insurance plans that is on par with coverage for other health concerns (i.e., mental health parity).[73] Benefits and services covered include such things as the number of visits, co-pays, deductibles, inpatient/outpatient services, prescription drugs, and hospitalizations. If a state has a stronger mental health parity law than the federal parity law, then insurance plans regulated by the state must follow the state parity law. If a state has a weaker parity law than the federal parity law (e.g., includes coverage for some mental health conditions but not others), then the federal parity law will replace the state law. Equal coverage does not necessarily imply good coverage as health insurance plans vary in the extent to which benefits and services are offered to address various health conditions. Rather it helps to ensure that mental health services are covered on par with other health concerns.

Reduce provider shortages in underserved areas. Access to effective and state-of-the-art mental health care is largely dependent upon the training and the size of the mental health care workforce. Over 85 million Americans live in areas with an insufficient number of mental health providers; this shortage is particularly severe among low-income urban and rural communities.[74] There are various ways to increase the number and distribution of practicing mental health providers in underserved areas including offering financial incentives through existing state and federal programs (e.g., loan repayment programs) and expanding the reach of health services through telephone, video and web-based technologies. Such approaches can increase the likelihood that those in need will be able to access affordable, quality care for mental health problems, which can reduce risk for suicide.

Safer suicide care through systems change. Access to health and behavioral health care services is critical for people at risk of suicide; however this is just one piece of the puzzle. Care should also be delivered efficiently and effectively. More specifically, care should take place within a system that supports suicide prevention and patient safety through strong leadership, workforce training, systematic identification and assessment of suicide risk, implementation of evidence-based treatments (see *Identify and Support People at Risk*), continuity of care, and continuous quality improvement. Care that is patient-centered and promotes equity for all patients is also of critical importance.[75]

Potential Outcomes

- Increased use of mental health services
- Lower rates of treatment attrition
- Reductions in depressive symptoms
- Reductions in rates of suicide attempts
- Reductions in rates of suicide

Evidence

There is evidence suggesting that coverage of mental health conditions in health insurance policies and improving access and the delivery of care can reduce risk factors associated with suicide and may directly impact suicide rates.

Coverage of mental health conditions in health insurance policies. The *National Survey on Drug Use and Health (NSDUH)* is a nationally representative survey of the U.S. population that provides data on substance use, mental health conditions, and service utilization.[50] Using data from this survey, Harris, Carpenter, and Bao[76] found that 12 months after states enacted *mental health parity laws*, self-reported use of mental healthcare services significantly increased. Moreover, subsequent research by Lang[69] examined state mental health laws and suicide rates between 1990 and 2004 and found that mental health parity laws, specifically, were associated with an approximate 5% reduction in suicide rates. This reduction, in the 29 states with parity laws, equated to the prevention of 592 suicides per year.[69]

Reduce provider shortages in underserved areas. One example of a program to improve access to mental health care providers is the *National Health Service Corps (NHSC)*, which offers financial incentives to attract mental/behavioral health clinicians to underserved areas.[77] Programs such as *NHSC* encourage individuals to work in the mental health profession in locations designated as Health Professional Shortage Areas (HPSAs) in exchange for student loan debt repayment. A 2012 retention survey conducted by the Health Resources and Services Administration (HRSA), found that 61% of mental and behavioral health care providers continued to practice in designated mental health shortage areas after their four year commitment to the *NHSC*.[78] Although this program has not been evaluated for impact on suicide, it addresses access to care, which is a critical component to suicide prevention.

Telemental Health (TMH) services refer to the use of telephone, video and web-based technologies for providing psychiatric or psychological care at a distance.[79] *TMH* can be used in a variety of settings (e.g., outpatient clinics, hospitals, military treatment facilities) to treat a wide range of mental health conditions. It can also improve access to care for patients in isolated areas, as well as reduce travel time and expenses, reduce delays in receiving care, and improve satisfaction interacting with the mental health care system. A systematic review of *TMH* services found that services rated as high or good quality were effective in treating mental health conditions such as depression, schizophrenia, substance



abuse, and suicidal ideation and suicide.[79] Further, Mohr and colleagues[80] conducted a meta-analysis examining the effect of psychotherapy delivered specifically via telephone and found that it significantly reduced depressive symptoms in comparison to face-to-face psychotherapy. They also found that treatment attrition rates were significantly lower among patients receiving telephone-administered psychotherapy compared to patients receiving face-to-face therapy.[80] Thus, *TMH* may not only offer improved access to mental health care, but it may also ensure continuity of care, and thereby further reduce the risk for suicide.

Safer suicide care through systems change. *Henry Ford Health System*, which is a large health maintenance organization (HMO) in the state of Michigan, pioneered *Perfect Depression Care,*[81] the pre-cursor to what is now called *Zero Suicide*. The overall goal of *Perfect Depression Care* was to eliminate suicide among HMO members. More broadly, the goal of the program was to redesign delivery of depression care to achieve "breakthrough improvement" in quality and safety by focusing on effectiveness, safety, patient centeredness, timeliness, efficiency, and equity among patients. The program screened and assessed each patient for suicide risk and implemented coordinated continuous follow-up care system wide.[81] An examination of the impact of the program found that there was a dramatic and statistically significant decrease in the rate of suicide between the baseline years, 1999 and 2000, and the intervention years, 2002-2009. During this time period, the suicide rate fell by 82%.[81,82] Further, among HMO members who received mental health specialty services, the suicide rate significantly decreased over time from 1999 to 2010 (110.3 to 47.6 per 100,000 population; $p<.04$) with a mean of 36.2 per 100,000 over the period.[83] Additionally, for those HMO members who accessed only general medical services as opposed to specialty mental health services, the suicide rate increased from 2.7 to 5.6 per 100,000 ($p<.01$).[83] Similarly, in the state of Michigan, rates of suicide in the general population increased over the period from 9.8 to 12.5 per 100,000 ($p<.001$).[83]



Create Protective Environments

Rationale

Prevention efforts that focus not only on individual behavior change (e.g., help-seeking, treatment interventions) but on changes to the environment can increase the likelihood of positive behavioral and health outcomes.[84] Creating environments that address risk and protective factors where individuals live, work, and play can help prevent suicide.[1,17] For example, rates of suicide are high among middle-aged adults who comprise 42.6% of the workforce[85]; among certain occupational groups[10,11]; and among people in detention facilities (e.g., jail, prison),[86] to name a few. Thus, settings where these populations work and reside are ideal for implementing programs, practices and policies to buffer against suicide. Changes to organizational culture through the implementation of supportive policies, for instance, can change social norms, encourage help-seeking, and demonstrate that good health and mental health are valued and that stigma and other risk factors for suicide are not.[87,88] Similarly, modifying the characteristics of the physical environment to prevent harmful behavior such as access to lethal means can reduce suicide rates, particularly in times of crisis or transition.[89-94]

Approaches

The current evidence suggests three potential approaches for creating environments that protect against suicide.

Reduce access to lethal means among persons at risk of suicide. Means of suicide such as firearms, hanging/suffocation, or jumping from heights provide little opportunity for rescue and, as such, have high case fatality rates (e.g., about 85% of people who use a firearm in a suicide attempt die from their injury).[95] Research also indicates that: 1) the interval between deciding to act and attempting suicide can be as short as 5 or 10 minutes,[96,97] and 2) people tend *not* to substitute a different method when a highly lethal method is unavailable or difficult to access.[98,99] Therefore, increasing the time interval between deciding to act and the suicide attempt, for example, by making it more difficult to access lethal means, can be lifesaving. The following are examples of approaches reducing access to lethal means for persons at risk of suicide:

- *Intervening at Suicide Hotspots.* Suicide hotspots, or places where suicides may take place relatively easily, include tall structures (e.g., bridges, cliffs, balconies, and rooftops), railway tracks, and isolated locations such as parks. Efforts to prevent suicide at these locations include erecting barriers or limiting access to prevent jumping, and installing signs and telephones to encourage individuals who are considering suicide, to seek help.[100]

- *Safe Storage Practices.* Safe storage of medications, firearms, and other household products can reduce the risk for suicide by separating vulnerable individuals from easy access to lethal means. Such practices may include education and counseling around storing firearms locked in a secure place (e.g., in a gun safe or lock box), unloaded and separate from the ammunition; and keeping medicines in a locked cabinet or other secure location away from people who may be at risk or who have made prior attempts.[89,101]

Organizational policies and culture that promote protective environments may be implemented in places of employment, detention facilities, and other secured environments (e.g., residential settings). Such policies and cultural values encourage leadership from the top down and may promote prosocial behavior (e.g., asking for help), skill building, positive social norms, assessment, referral and access to helping services (e.g., mental health, substance abuse treatment, financial counseling), and development of crisis response plans, postvention and other measures to foster a safe physical environment. Such policies and cultural shifts can positively impact organizational climate and morale and help prevent suicide and its related risk factors (e.g., depression, social isolation).[88,102]

Community-based policies to reduce excessive alcohol use. Research studies in the United States have found that greater alcohol availability is positively associated with alcohol-involved suicides.[103-105] Policies to reduce excessive alcohol use broadly include zoning to limit the location and density of alcohol outlets, taxes on alcohol, and bans on the sale of alcohol for individuals under the legal drinking age.[105] These policies are important because acute alcohol use has been found to be associated with more than one-third of suicides and approximately 40% of suicide attempts.[106]



Potential Outcomes

- Increases in safe storage of lethal means
- Reductions in rates of suicide
- Reductions in suicide attempts
- Increases in help-seeking
- Reductions in alcohol-related suicide deaths

Evidence

The evidence suggests that creating protective environments can reduce suicide and suicide attempts and increase protective behaviors.

Reduce access to lethal means among persons at risk of suicide. A meta-analysis examining the impact of *suicide hotspot interventions* implemented in combination or in isolation, both in the U.S. and abroad, found associated reduced rates of suicide.[100,107] For example, after erecting a barrier on the Jacques-Cartier bridge in Canada, the suicide rate from jumping from the bridge decreased from about 10 suicide deaths per year to about 3 deaths per year.[108] Moreover, the reduction in suicides by jumping was sustained even when all bridges and nearby jumping sites were considered, suggesting little to no displacement of suicides to other jumping sites.[108] Further evidence for the effectiveness of bridge barriers was demonstrated by a study examining the impact of the *removal* of safety barriers from the Grafton Bridge in Auckland, New Zealand. After removal of the barrier, both the number and rate of suicide increased five-fold.[93,109]

Another form of means reduction involves implementation of *safe storage practices*. In a case-control study of firearm-related events identified from 37 counties in Washington, Oregon, and Missouri, and from 5 trauma centers, researchers found that storing firearms unloaded, separate from ammunition, in a locked place or secured with a safety device was protective of suicide attempts among adolescents.[110] Further, a recent systematic review of clinic and community-based education and counseling interventions suggested that the provision of safety devices significantly increased safe firearm storage practices compared to counseling alone or compared to the provision of economic incentives to acquire safety devices on one's own.[101]

Another program, the *Emergency Department Counseling on Access to Lethal Means (ED CALM)*, trained psychiatric emergency clinicians in a large children's hospital to provide lethal means counseling and safe storage boxes to parents of patients under age 18 receiving care for suicidal behavior. In a pre-post quality improvement project, Runyan et al[89] found that at post-test 76% (of the 55% of parents followed up, n=114) reported that all medications in the home were locked up as compared to fewer than 10% at the time of the initial emergency department visit. Among parents who indicated the presence of guns in the home at pre-test (i.e., 67%), all (100%) reported guns were currently locked up at post-test.[89]

Organizational policies and culture. *Together for Life* is a workplace program of the Montreal Police Force implemented to address suicide among officers. Policy and program components were designed to foster an organizational culture that promoted mutual support and solidarity among all members of the Force. The program included training of supervisors, managers and all units to improve competencies in identifying suicidal risk and to improve use and awareness of existing resources. The program also included an education campaign to improve awareness and help-seeking.[111] Police suicides were tracked over 12 years and compared to rates in the control city of Quebec. The suicide rate in the intervention group decreased significantly by 78.9% to a rate of 6.4 suicides per 100,000 population per year compared to an 11% increase in the control city (29.0 per 100,000).[111]

Another example of this approach is the *United States Air Force Suicide Prevention Program*. The program included 11 policy and education initiatives and was designed to change the culture of the Air Force surrounding suicide. The program uses leaders as role models and agents of change, establishes expectations for behavior related to awareness of suicide risk, develops population skills and knowledge (i.e., education and training), and investigates every suicide (i.e., outcomes measurement). The program represents a fundamental shift from viewing suicide and mental illness solely as medical problems and instead sees them as larger service-wide problems impacting the whole community.[112] Using a time-series design to examine the impact of the program on various violence-related outcomes, researchers found that the program was associated with a 33% relative risk reduction in suicide.[112] The program was also associated with relative risk reductions in related outcomes including moderate and severe family violence (30% and 54%, respectively), homicide (51%), and accidental death (18%).[112] A longitudinal assessment of the program over the period 1981 to 2008 (16 years before the 1997 launch of the program and 11 years post-launch) found significantly lower rates of suicide after the program was launched than before.[87] These effects were sustained over time, except in 2004, which the authors found was associated with less rigorous implementation of program components in that year than in the other years.[87]

Finally, while the evidence is still being built for suicide prevention in correctional facilities, preliminary evidence suggests organizational policies and practices that include routine suicide prevention training for all staff; standardized intake screening and risk assessment; provision of shared information between staff members (especially in transitioning or transferring of inmates); varying levels of observation; safe physical environment; emergency response protocols; notification of suicidal behavior/suicide through the chain of command; and critical incident stress debriefing and death review can potentially reduce suicide.[102] When these policies and practices were implemented across 11 state prisons in Louisiana, suicide rates dropped 46%, from a rate of 23.1 per 100,000 before the intervention to 12.4 per 100,000 the following year.[113] Similar programs have seen declines in suicide both in the United States and in other countries.[114]

Community-based policies to reduce excessive alcohol use. While multiple policies to limit excessive use of alcohol exist, several studies on alcohol outlet density and risk factors for suicide, such as interpersonal violence and social connectedness,[115-118] suggest that measures to reduce alcohol outlet density can potentially reduce alcohol-involved suicides. Additionally, a longitudinal analysis of alcohol outlet density, suicide mortality, and hospitalizations for suicide attempts over 6 years in 581 California zip codes, indicated that greater density of bars, specifically, was related to greater suicide and suicide attempts, particularly in rural areas.[119]



Promote Connectedness

Rationale

Sociologist, Emile Durkheim theorized in 1897 that weak social bonds, i.e., lack of connectedness, were among the chief causes of suicidality.[120] Connectedness is the degree to which an individual or group of individuals are socially close, interrelated, or share resources with others.[121] Social connections can be formed within and between multiple levels of the social ecology,[17] for instance between individuals (e.g., peers, neighbors, co-workers), families, schools, neighborhoods, workplaces, faith communities, cultural groups, and society as a whole. Related to connectedness, social capital refers to a sense of trust in one's community and neighborhood, social integration, and also the availability and participation in social organizations.[122,123] Many ecological cross-sectional and longitudinal studies have examined the impact of aspects of social capital on depression symptoms, depressive disorder, mental health more generally, and suicide. While the evidence is limited, existing studies suggest a positive association between social capital (as measured by social trust and community/neighborhood engagement), and improved mental health.[124,125] Connectedness and social capital together may protect against suicidal behaviors by decreasing isolation, encouraging adaptive coping behaviors, and by increasing belongingness, personal value, and worth, to help build resilience in the face of adversity. Connectedness can also provide individuals with better access to formal supports and resources, mobilize communities to meet the needs of its members and provide collective primary prevention activities to the community as a whole.[121]

Approaches

Promoting connectedness among individuals and within communities through modeling peer norms and enhancing community engagement may protect against suicide.

Peer norm programs seek to normalize protective factors for suicide such as help-seeking, reaching out and talking to trusted adults, and promote peer connectedness. By leveraging the leadership qualities and social influence of peers, these approaches can be used to shift group-level beliefs and promote positive social and behavioral change. These approaches typically target youth and are delivered in school settings but can also be implemented in community settings.[126]

Community engagement activities. Community engagement is an aspect of social capital.[127] Community engagement approaches may involve residents participating in a range of activities, including religious activities, community clean-up and greening activities, and group physical exercise. These activities provide opportunities for residents to become more involved in the community and to connect with other community members, organizations, and resources, resulting in enhanced overall physical health, reduced stress, and decreased depressive symptoms, thereby reducing risk of suicide.

Potential Outcomes

- Increases in healthy coping attitudes and behaviors
- Increases in referrals for youth in distress
- Increases in help-seeking behaviors
- Increases in positive perceptions of adult support



Evidence

Current evidence suggests a number of positive benefits of peer norm and community engagement activities, although more evaluation research is needed to examine whether these improvements in factors that protect against suicidal behavior translate into reduced suicide attempts and deaths.

Peer norm programs. Evaluations show that programs such as *Sources of Strength* can improve school norms and beliefs about suicide that are created and disseminated by student peers. In a randomized controlled trial of *Sources of Strength* conducted with 18 high-schools (6 metropolitan, 12 rural), researchers found that the program improved adaptive norms regarding suicide, connectedness to adults, and school engagement.[36] Peer leaders were also more likely than controls to refer a suicidal friend to an adult. For students, the program resulted in increased perceptions of adult support for suicidal youths, particularly among those with a history of suicidal ideation, and the acceptability of help-seeking behaviors. Finally, trained peer leaders also reported a greater decrease in maladaptive coping attitudes compared with untrained leaders.[36]



Community engagement activities. A vacant lot greening initiative was undertaken in Philadelphia between 1999 and 2008. Local residents and community members worked together to green 4,436 lots (or 7.8 million square feet) in four areas of the city. Researchers found significant reductions in community residents' self-reported level of stress, a risk factor for suicide, and engagement in more physical exercise, a protective factor for suicide, than residents in control vacant lot areas. There is some evidence for other cross-cutting benefits, including reductions in firearm assaults and vandalism.[128,129]



Teach Coping and Problem-Solving Skills

Rationale

Building life skills prepares individuals to successfully tackle every day challenges and adapt to stress and adversity. Life skills encompasses many concepts, but most often include coping and problem-solving skills, emotional regulation, conflict resolution, and critical thinking. Life skills are important in protecting individuals from suicidal behaviors.[126] Suicide prevention programs that focus on life and social skills training are drawn from social cognitive theories,[130] surmising that suicidal behavior is attributed to either direct learning and modeling or environmental and individual (e.g., hopelessness) characteristics. The inability to employ adequate strategies to cope with immediate stressors or identify and find solutions for problems has been characterized among suicide attempters.[131] Teaching and providing youth with the skills to tackle every day challenges and stressors is, therefore, an important developmental component to suicide prevention.

Approaches

Social-emotional learning programs and parenting skill and family relationship programs are two approaches for teaching coping and problem-solving skills.

Social-emotional learning programs focus on developing and strengthening communication and problem-solving skills, emotional regulation, conflict resolution, help seeking and coping skills. These approaches address a range of risk and protective factors for suicidal behavior. They provide children and youth with skills to resolve problems in relationships, school, and with peers, and help youth address other negative influences (e.g., substance use) associated with suicide.[126] These approaches are typically delivered to all students in a particular grade or school, although some programs also focus on groups of students considered to be at high risk for suicide. Opportunities to practice and reinforce skills are an important part of programs that work.[132]

Parenting skill and family relationship programs provide caregivers with support and are designed to strengthen parenting skills, enhance positive parent-child interactions, and improve children's behavioral and emotional skills and abilities.[132] Programs are typically designed for parents or caregivers with children in a specific age range and can be self-directed or delivered to individual families or groups of families. Some programs have sessions primarily with parents or caregivers while others include sessions for parents or caregivers, youth, and the family. Specific program content typically varies by the age of the child but often has consistent themes of child development, parent-child communication and relationships, and youth's interpersonal and problem-solving skills.

Potential Outcomes

- Reductions in suicide ideation
- Reductions in suicide attempts
- Reductions in suicide risk behaviors (i.e., depression, anxiety, conduct problems, substance abuse)
- Improvements in help-seeking behavior
- Improvements in social competence and emotional regulation skills
- Improvements in problem-solving and conflict management skills

Evidence

Several social-emotional learning and parenting and family relationship programs have been shown in rigorous evaluations to improve resilience and reduce problem behavior and risk factors for various behaviors, including ones closely related to suicide, such as depression, internalizing behaviors, and substance abuse.[133]

Social-emotional learning programs. The *Youth Aware of Mental Health Program (YAM)* is a program developed for teenagers aged 14–16 that uses interactive dialogue and role-playing to teach adolescents about the risk and protective factors associated with suicide (including knowledge about depression and anxiety) and enhances their problem-solving skills for dealing with adverse life events, stress, school and other problems.[134] In a cluster-randomized controlled trial conducted across 10 European Union countries and 168 schools, students in schools randomized to *YAM* were significantly less likely to attempt suicide and have severe suicidal ideation at the 12-month follow-up compared to students in control schools which received educational materials and care as usual. Overall, the relative risk of youth suicide attempts among the *YAM* group was reduced by over 50% demonstrating that out of 1000 students, five attempted suicide in the *YAM* group compared to 11 in the control group. Additionally, related to severe suicide ideation, in the *YAM* group, relative risk fell by 49.6%.[134]

Another example is the *Good Behavior Game (GBG)*, which is a classroom-based program for elementary school children aged 6–10. The program uses a team-based behavior management strategy that promotes good behavior by setting clear expectations for good behavior and consequences for maladaptive behavior. The goal of the *GBG* program is to create an integrated classroom social system that is supportive of all children being able to learn with little aggressive or disruptive behavior.[135] Two cohorts of youths participated in the program in 1985-86 and 1986-87 school years when they were in the first and second grades. A number of proximal and distal outcomes were assessed among the two cohorts over time. With respect to distal suicide-related outcomes, an outcome evaluation of the *GBG* indicated that individuals in the first cohort, who were assigned to participate in *GBG* when they were in the first grade, reported half the adjusted odds of suicidal ideation and suicide attempts when assessed approximately 15 years later, between the ages of 19 to 21, compared to peers who had been in a standard classroom setting. The beneficial effect of the program was consistent for suicidal ideation regardless of whether baseline covariates were included.[135] The *GBG* effect on attempts was less robust in some adjusted models including caregiver mental health. In the second cohort of *GBG* students, neither suicidal ideation nor suicide attempts were significantly different between *GBG* and the control interventions.[135] The researchers believed this may have been due to a lack of implementation fidelity, including less mentoring and monitoring of teachers. *GBG* was also found to be associated with reduced risk of later substance abuse and other suicide risk factors among the first cohort of students. Results for the second cohort were generally smaller but in the desired direction.[136]

Parenting skill and family relationship programs. Parenting and family skills training approaches have shown promising impacts in preventing key risk factors associated with suicide. For example, the *Incredible Years (IY)* is a comprehensive group training program for parents, teachers and children designed to reduce conduct and substance abuse problems (two important suicide risk factors in youth) by improving protective factors such as responsive and positive parent-teacher-child interactions and relationships, emotional self-regulation and social competence (all protective factors for suicide).[132] The program includes 9-20 sessions offered in community-based settings (e.g., religious, recreation centers, mental health treatment centers, and hospitals). Several studies have demonstrated the effect of the *IY* program on reducing internalizing symptoms, such as anxiety and depression, and child conduct problems.[137,138] The program is also associated with improved problem-solving and conflict management; these skills were maintained at 1-year follow-up.[139-141] Additionally, the program demonstrated greater benefits in mother-rated child internalizing symptoms, compared to the waitlisted control group, when parent, child, and teacher components were included.[132]

Additionally, *Strengthening Families 10–14* is a program that involves sessions for parents, youth, and families with the goal of improving parents' skills for disciplining, managing emotions and conflict, and communicating with their children; promoting youths' interpersonal and problem-solving skills; and creating family activities to build cohesion and positive parent-child interactions. The premise of the program is that developing these skills for both parents and children will reduce internalizing behavior and adolescent substance abuse, two important risk factors for suicide.[142] *Strengthening Families* has been shown to significantly decrease externalizing behaviors, such as aggression, alcohol use, and drug use among youth participants, as well as reduce depression, alcohol use, and drug use among participating families.[142]





Identify and Support People at Risk

Rationale

In order to decrease suicide, care of, and attention to, vulnerable populations is necessary, as these groups tend to experience suicidal behavior at higher than average rates. Such vulnerable populations include, but are not limited to, individuals with lower socio-economic status or who are living with a mental health problem; people who have previously attempted suicide; Veterans and active duty military personnel; individuals who are institutionalized, have been victims of violence, or are homeless; individuals of sexual minority status; and members of certain racial and ethnic minority groups.[8,9,12,13,143] Supporting people at risk requires proactive case finding and effective response, crisis intervention, and evidence-based treatment. Finding optimal ways of identifying at risk individuals, customizing services to make them more accessible (e.g., Internet-based services when appropriate) and engaging people in evidence-based care (e.g., through such measures as collaborative treatment), remain key challenges.[81,144,145] Simply improving or expanding services does not guarantee that those services will be used by people most in need, nor will it necessarily increase the number of people who follow recommended referrals or treatment. For example, some people living in disadvantaged communities may face social and economic issues that can adversely affect their ability to access supportive services.[70]

Approaches

The following approaches focus on identifying and supporting people at increased risk of suicide.

Gatekeeper training is designed to train teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating treatment seeking and support services. Gatekeeper training may be implemented in a variety of settings to identify and support people at risk.[146]

Crisis intervention. These approaches provide support and referral services, typically by connecting a person in crisis (or a friend or family member of someone at risk) to trained volunteers or professional staff via telephone hotline, online chat, text messaging, or in-person. Crisis intervention approaches are intended to impact key risk factors for suicide, including feelings of depression, hopelessness, and subsequent mental health care utilization.[147] Similar to means reduction, crisis interventions can put space or time between an individual who may be considering suicide and harmful behavior.

Treatment for people at risk of suicide can include various forms of psychotherapy delivered by licensed providers to help individuals with mental health problems and other suicide risk factors with problem-solving and emotional regulation. Treatment usually takes place in a one-on-one or group format between patients and clinicians and can vary in duration from several weeks to ongoing therapy, as needed. Treatment that employs collaborative (i.e., between patient and therapist or care manager) and/or integrated care (e.g., linkage between primary care and behavioral health care) can help engage and motivate patients, thereby increasing retention in therapy and decreasing suicide risk.[148-150]



Treatment to prevent re-attempts. These approaches typically include follow-up contact and use diverse modalities (e.g., home visits, mail, telephone, e-mail) to engage recent suicide attempt survivors in continued treatment to prevent re-attempts.[151] Treatment may focus on improved coping skills, mindfulness, and other emotional regulation skills, and may include case management home visits to increase adherence to treatment and continuity of care; and one-on-one interpersonal therapy and/or group therapy. Approaches that engage and connect people who have attempted to peers and providers are especially important because many attempters do not present to aftercare; 12%-25% re-attempt within a year, and 3%-9% of attempt survivors die by suicide within 1 to 5 years of their initial attempt.[151]

Potential Outcomes

- Reductions in suicidal ideation
- Reductions in suicide attempts
- Reductions in suicide rates
- Reductions in depression and feelings of hopelessness
- Reductions in re-attempts
- Improvements in coping skills
- Increases in treatment engagement and compliance with medications

Evidence

The current evidence suggests that identifying people at risk of suicide and the continued provision of treatment and support for these individuals can positively impact suicide and its associated risk factors.

Gatekeeper training. *Applied Suicide Intervention Skills Training (ASIST)* is a widely implemented training program that helps hotline counselors, emergency workers, and other gatekeepers to identify and connect with suicidal individuals, understand their reasoning for living and dying, and assist with safely connecting those in need to available resources. In a study employing a randomized controlled trial, Gould, Cross, Pisani, Munfakh, & Kleinman[152] evaluated the training across the *National Suicide Prevention Lifeline* network of hotlines over the period 2008-2009. Using data from 1,410 suicidal individuals who called 17 Lifeline centers, the researchers found that callers who spoke with *ASIST*-trained

counselors were significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful by the end of their call, compared to callers who spoke to non-*ASIST* trained counselors. Counselors trained in *ASIST* were also more skilled at keeping callers on the phone longer and establishing a connection with them. However, training in *ASIST* did not result in more comprehensive suicide risk assessments than usual care training.[152]

Gatekeeper training has also been a primary component of the *Garret Lee Smith (GLS) Suicide Prevention Program,* which has been implemented in 50 states and 50 tribes. A multi-site evaluation assessed the impact of community gatekeeper training on suicide attempts and deaths by comparing the change in suicide rates and nonfatal suicidal behavior among young people aged 10–24 in counties implementing *GLS* trainings, with the trajectory observed in similar counties that did not implement these trainings. Counties that implemented *GLS* trainings had significantly lower youth suicide rates one year following the training implementation.[153] This finding equates to a decrease of 1 suicide death per 100,000 youth ages 10 to 24, or the prevention of approximately 237 deaths in the age group, between 2007 and 2010. Counties implementing *GLS* program activities also had significantly lower suicide attempt rates among youth ages 16 to 23 in the year following implementation of the *GLS* program than did similar counties that did not implement *GLS* activities (4.9 fewer attempts per 1000 youths).[154] More than 79,000 suicide attempts may have been prevented during the period examined.

Crisis intervention. Suicide prevention hotlines are one way to provide crisis intervention. In an evaluation of the effectiveness of the *National Suicide Prevention Lifeline* to prevent suicide, 1,085 suicidal individuals who called the hotline completed a standard risk assessment for suicide, and 380 of those completed a follow-up assessment between 1 and 52 days (mean=13.5 days) after the initial assessment. Researchers found that over half of the initial sample were seriously considering suicide when they called, and they had a plan for their suicide. Researchers also found that among follow-up participants, there was a significant decrease in psychological pain, hopelessness, and intent to die between initiation of the call (time 1) to follow-up (time 3).[155] Between time 2 (end of the call) to time 3, the effect remained for psychological pain and hopelessness, but was not significant for intent to die, suggesting that greater effort at outreach during and following the call is needed for callers with high levels of suicide intent.[155]

Treatment for people at risk of suicide. The *Improving Mood—Promoting Access to Collaborative Treatment (IMPACT)* program aims to prevent suicide among older primary care patients by reducing suicide ideation and depression. *IMPACT* facilitates the development of a therapeutic alliance, a personalized treatment plan that includes patient preferences, as well as proactive follow-up (biweekly during an acute phase and monthly during continuation phase) by a depression care manager.[156] The program has been shown to significantly improve quality of life, and to reduce functional impairment, depression and suicidal ideation over 24-months of follow-up[156,157] relative to patients who received care as usual.

Collaborative Assessment and Management of Suicidality (CAMS), is a therapeutic approach for suicide-specific assessment and treatment. The program's flexible approach can be used across treatment settings and clinician theoretical orientations and involves the clinician and patient working together in an interactive assessment process to develop patient-specific treatment plans. Sessions are collaborative and involve constant patient input about what is and is not working with the ultimate goal of enhancing the therapeutic alliance and increasing treatment motivation in the suicidal patient. *CAMS* has been tested and supported in 6 correlational studies,[144] in a variety of inpatient and outpatient settings, and in one RCT with several additional RCTs under way. A feasibility trial with a community-based sample of suicidal outpatients randomly assigned to *CAMS* or enhanced care as usual (intake with a psychiatrist or psychiatric nurse practitioner followed by 1-11 visits with a case manager and medication as needed) found better treatment retention among the *CAMS* group and significant improvements in suicidal ideation, overall symptom distress, and feelings of hopelessness at the 12 month follow-up.[158]

Other examples include *Dialectical Behavioral Therapy (DBT)* and *Attachment-Based Family Therapy (ABFT). DBT* is a multicomponent therapy for individuals at high risk for suicide and who may struggle with impulsivity and emotional regulation issues. The components of *DBT* include individual therapy, group skills training, between-session telephone coaching and a therapist consultation team. In a randomized controlled trial of women with recent suicidal or self-injurious behavior, those receiving *DBT* were half as likely to make a suicide attempt at the two-year follow-up than women receiving community treatment (23% vs 46%), required less hospitalization for suicide ideation, and had lower medical risk across all suicide attempts and self-injurious acts combined.[159]

ABFT is a program for adolescents aged 12–18 and is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety.[160] A randomized controlled trial of *ABFT* found that suicidal adolescents assigned to *ABFT* experienced significantly greater improvement in suicidal ideation over 24 weeks of follow-up than did adolescents assigned to enhanced usual care. Additionally, a significantly higher percentage of *ABFT* participants reported no suicidal ideation in the week prior to assessment at 12 weeks than did adolescents receiving enhanced usual care (69.2% vs. 34.6%) and at 24 weeks (82.1% vs. 46.2%).[160]

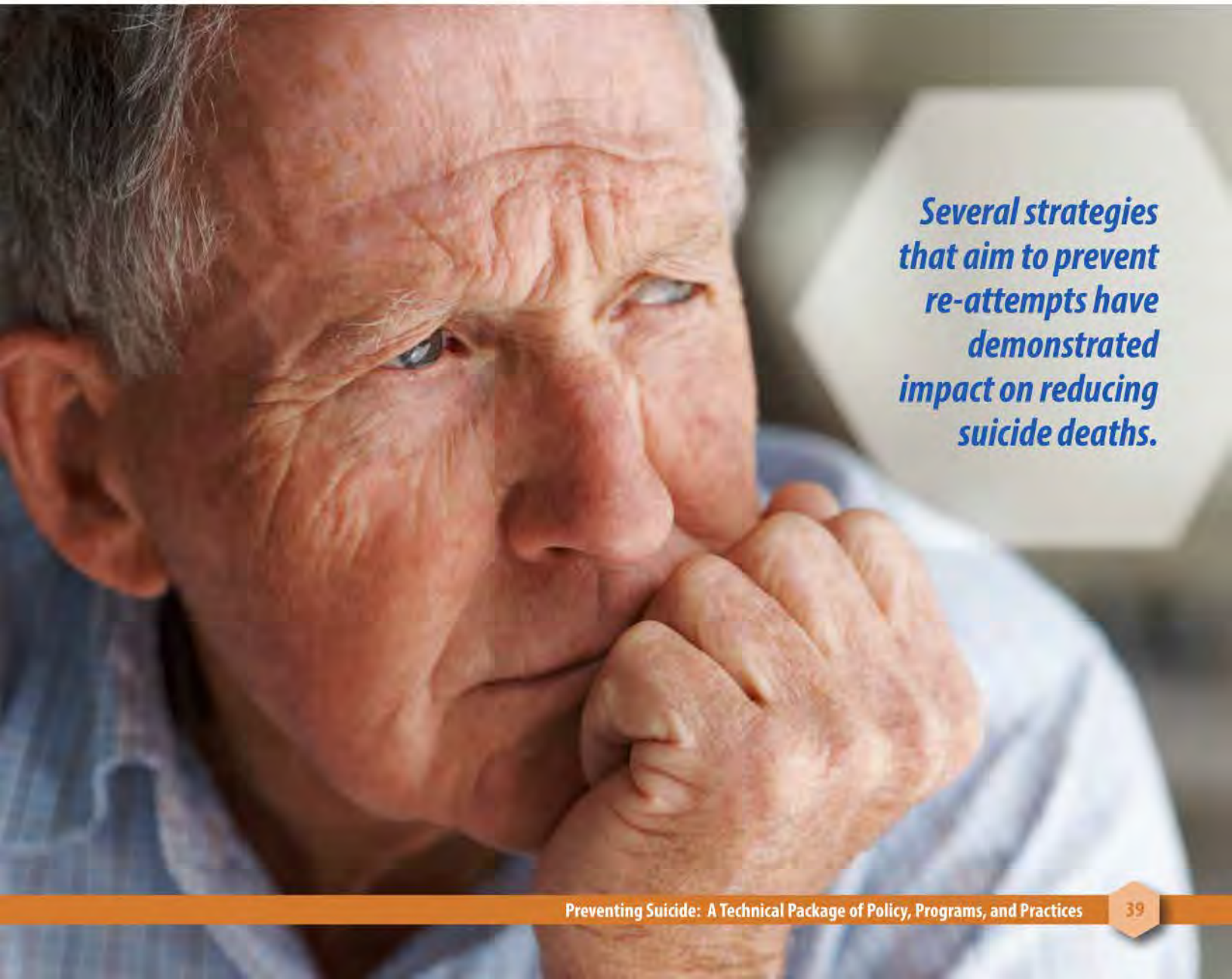
The Veterans Affairs *Translating Initiatives for Depression into Effective Solutions* project (*TIDES*) uses a depression care liaison to link primary care and mental health services. The depression care liaison assesses and educates patients and follows-up with both patients and providers between primary care visits to optimize treatment. This collaborative care increases the efficiency of providing mental health services by bringing mental health care to the primary care setting, where most patients are first detected and subsequently treated for many mental health conditions. An evaluation of *TIDES* found significant decreases in depression severity scores among 70% of primary care patients.[161] *TIDES* patients also demonstrated 85% and 95% compliance with medication and follow-up visits, respectively.[161]

Treatment to prevent re-attempts. Several strategies that aim to prevent re-attempts have demonstrated impact on reducing suicide deaths. For example, *Emergency Department Brief Intervention with Follow-up Visits* is a program that involves a one-hour discharge information session that addresses suicidal ideation and attempts, distress, risk and protective factors, alternatives to self-harm, and referral options, combined with nine follow-up contacts over 18 months (at 1, 2, 4, 7, 11 weeks and 4, 6, 12, 18 months). Follow-up contacts are either conducted by phone or through home visits according to a specific timeline for up to 18 months. A randomized controlled trial that enrolled suicide attempters from eight hospital emergency departments in five countries (Brazil, India, Sri Lanka, Iran, and China) found that a brief intervention combined with nine follow-up visits over 18 months was associated with significantly fewer deaths from suicide relative to a treatment-as-usual group (0.2% versus 2.2%, respectively).[162]

Another example of treatment to prevent re-attempts involves *active follow-up contact approaches* such as postcards, letters, and telephone calls intended to increase a patient's sense of connectedness with health care providers and decrease isolation.[151] These approaches include expression of care and support and typically invite patients to reconnect with their provider. Contacts are made periodically (e.g., monthly or every few months in the first 12 months post-discharge with some programs continuing contact for two or more years). In a meta-analysis conducted by Inagaki et al[151] interventions to prevent repeat suicide attempts in patients admitted to an emergency department for suicide attempt were found to reduce re-attempts by approximately 17% for up to 12 months post-discharge; however, the effects of these approaches beyond 12 months on re-attempts has not yet been demonstrated.[151] Also, because the number of trials and associated sample sizes included in this meta-analysis were small, it was not possible to determine the effect of active contact and follow-up approaches on suicide.

In a randomized controlled trial of the post-crisis suicide prevention long-term follow-up contact approach, Motto and Bostrom[163] found that patients who refused ongoing care but who were randomized to be contacted by letter four times per year had a lower rate of suicide over two years of follow-up than did patients in the control group who received no further contact. Other studies have also shown post-crisis letters and coping cards to be protective against suicide ideation and attempts.[164,165]

Finally, *Cognitive Behavior Therapy for Suicide Prevention (CBT-SP)* is an example of a therapeutic approach to prevent re-attempts. It uses a risk-reduction, relapse prevention approach that includes an analysis of proximal risk factors and stressors (e.g., relationship problems, school or work-related difficulties) leading up to and following the suicide attempt; safety plan development; skill building; and psychoeducation. *CBT-SP* also has family skill modules focused on family support and communication patterns as well as improving the family's problem-solving skills. A randomized controlled trial of *CBT-SP* found that 10-session outpatient cognitive therapy designed to prevent repeat suicide attempts resulted in a 50% reduction in the likelihood of a suicide re-attempt among adults who had been admitted to an emergency department for a suicide attempt relative to treatment as usual.[166]




DAILY NEWS
BREAKING NEWS
ECONOMY
BUSINESS
POLITICS

Lessen Harms and Prevent Future Risk

Rationale

Millions of people are bereaved by suicide every year in the United States and throughout the world.[5] Risk of suicide and suicide risk factors has been shown to increase among people who have lost a friend/peer, family member, co-worker, or other close contact to suicide.[167] Care and attention to the bereaved is therefore of high importance. Despite often good intentions, media and others responding to suicide may add to this risk. For example, research suggests that exposure to sensationalized or otherwise uninformed reporting on suicide may heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to what is known as suicide contagion.[168,169]

Approaches

Some approaches that can be used to lessen harms and reduce future risk of suicide include postvention and safe reporting and messaging following a suicide.

Postvention approaches are implemented *after* a suicide has taken place and may include debriefing sessions, counseling, and/or bereavement support groups for surviving friends, family members, or other close contacts. These programs have not typically been evaluated for their impact on suicide, attempts, or ideation, but they may reduce survivors' guilt, feelings of depression, and complicated grief.[170]

Safe reporting and messaging about suicide. The manner in which information on a recent suicide is communicated to the public (e.g., school assemblies, mass media, social media) can heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion. Reports that are inclusive of suicide prevention messages, stories of hope and resilience, risk and protective factors, and links to helping resources (e.g., hotline), and that avoid sensationalizing events or reducing suicide to one cause, can help reduce the likelihood of suicide contagion.[171]

Potential Outcomes

- Reductions in suicidal ideation
- Reductions in suicide attempts
- Reductions in rates of suicide
- Reductions in psychological distress
- Improvements in reporting following suicide
- Reductions in contagion effects related to suicide



Evidence

Current evidence suggests that postvention and safe reporting and messaging can impact risk and protective factors for suicide.

Postvention. One example of a postvention program with evidence of impact on risk and protective factors for suicide is the *StandBy Response Service* (*StandBy*). *StandBy* provides clients with face-to-face outreach and telephone support through a professional crisis response team. Site coordinators develop customized case management plans, referring clients to other existing community services matched to their needs.[172] In a study by Visser, Comans, and Scuffham,[172] *StandBy* clients were significantly less likely to be at high risk for suicidality (suicide ideation and attempts) and had less psychological distress than a suicide bereaved comparison group who had not had contact with the *StandBy* program (48% and 64% respectively). Additionally, research suggests that active postvention approaches in which outreach to suicide survivors occurs at the scene of a suicide is associated with intake into treatment sooner, greater attendance at support group meetings, and attendance at more meetings compared to passive postvention (i.e., approaches where survivors self-refer for services).[173]

Safe reporting and messaging about suicide. One way to ensure safe reporting and messaging about suicide is to encourage news media to adhere to *Recommendations for Reporting on Suicide* (http://www.reportingonsuicide.org). The most compelling evidence supporting these recommendations for reporting comes from Austria. After a sharp increase in suicides on the Viennese subway, media guidelines were introduced and an interrupted time-series design was used to evaluate the national impact of the guidelines on subsequent suicides. Changes in the quality and quantity of media reporting resulted in a nationwide significant reduction of 81 suicides annually.[169] Finally, research suggests that not only does reporting on suicide in a negative way (e.g., reporting on suicide myths and repetition) have harmful effects on suicide, but reporting on positive coping skills in the face of adversity can also demonstrate protective effects against suicide.[174] Reports of individual suicidal ideation (not accompanied by reports of suicide or suicide attempts) along with reports describing a "mastery" of a crisis situation where adversities were overcome was associated with significant decreases in suicide rates in the time period immediately following such reports.[174]



Sector Involvement

Public health can play an important and unique role in addressing suicide. Public health agencies, which typically place prevention at the forefront of efforts and work to create broad population-level impact, can bring critical leadership and resources to bear on this problem. For example, these agencies can serve as a convener, bringing together partners and stakeholders to plan, prioritize, and coordinate suicide prevention efforts. Public health agencies are also well positioned to collect and disseminate data, implement preventive measures, evaluate programs, and track progress. Although public health can play a leadership role in preventing suicide, the strategies and approaches outlined in this technical package cannot be accomplished by the public health sector alone. As noted in the *National Strategy for Suicide Prevention,*[1] the integration and coordination of prevention activities across sectors and settings is critical for expanding the reach and impact of suicide prevention efforts.

Other sectors vital to implementing this package include, but are not limited to, education, government (local, state, and federal), social services, health services, business, labor, justice, housing, media, and organizations that comprise the civil society sector such as faith-based organizations, youth-serving organizations, foundations, and other non-governmental organizations. Collectively, these sectors can make a difference in preventing suicide by impacting the various contexts and underlying risks that contribute to suicide.

The strategies and approaches described in this technical package are summarized in the Appendix along with the relevant sectors that are well positioned to lead implementation efforts. For example, business and labor, the health sector (including insurers, providers, and health systems), and government entities are in the best position to implement programs and policies that *Strengthen Economic Supports* and *Strengthen Access and Delivery of Suicide Care*. These types of supports go beyond individual behavior change and require commitment and support from those sectors that can directly address some of the underlying risks and the environmental contexts that increase the risk for suicide. Public health entities can play an important role by gathering and synthesizing information to inform policy, raise awareness, and evaluate the effectiveness of various policies. Moreover, partnerships with non-governmental and community organizations can be instrumental in increasing awareness of and garnering support for policies affecting individuals and families.

The public health sector has been at the forefront of many community-based prevention efforts, working collaboratively with schools and community-based organizations, to change social norms and positively impact health behavior. Public health is well suited to take on a similar leadership role in *Promoting Connectedness* through peer norm and community engagement activities and supporting the development, evaluation, and adoption of effective programs that *Teach Coping and Problem-Solving Skills* to prevent the risk of suicide in the first place. These programs are often delivered in school and community settings, making education and non-governmental organizations vital partners in prevention.

Businesses, workplaces, and local and state government entities, on the other hand, are in the best position to establish policies and support practices that *Create Protective Environments* where people live, work, and play. Public health entities can serve in an important role by gathering and synthesizing information, working with other governmental agencies (e.g., criminal justice, defense) and agencies within the executive branch of their state or local government in support of policy and other approaches, and evaluating the effectiveness of measures taken. In a similar fashion, public health entities can partner with schools, workplaces, and community organizations to implement and evaluate prevention programs, policies and practices geared toward creating safe, healthy, and supportive environments.

Finally, this technical package includes a number of interventions delivered in hospital, primary care, behavioral health care, and community settings designed to *Identify and Support People at Risk*. The intensity and activities for many of these interventions require the expertise of professionals who are licensed and trained to deliver critical intervention support. The health, social services, and justice sectors can work collaboratively to support individuals at high-risk for suicide and their families. These activities also require coordination of supports across various service providers and community organizations.

Regardless of strategy, action by many sectors will be necessary for the successful implementation of this package. In this regard, all sectors can play an important and influential role in preventing the risk of suicide in the first place and lessening the immediate and long-term harms of suicidal behavior by helping those in times of crisis get the services and support they need.



Monitoring and Evaluation

Monitoring and evaluation are necessary components of the public health approach to prevention. It is important to have timely and reliable data to monitor the extent of the problem and to evaluate the impact of prevention efforts. Data are also necessary for prevention planning and implementation.

Gathering ongoing and systematic data is important for prevention efforts. However, it is also important to gather data that are uniform and consistent across systems. Consistent data allow public health and other entities to better gauge the scope of the problem, identify high-risk groups, and monitor the effects of prevention programs and policies. Currently, it is common for different sectors, agencies, and organizations to employ varying definitions of suicidal ideation, behavior, and death that can make it difficult to consistently monitor specific outcomes across sectors and over time. For example, the manner in which deaths are classified can change from one jurisdiction to another, and can change based on local medical and/or medico-legal standards.[4] CDC's uniform definitions and recommended data elements for self-directed violence provide a useful framework to help ensure that data are collected in a consistent manner across surveillance systems.[4]

Surveillance systems exist at the federal, state, and local levels. It is important to assess the availability of surveillance data and data systems across these levels to identify and address gaps in the systems. CDC's *National Vital Statistics System (NVSS)*[7] and the *National Violent Death Reporting System (NVDRS)*[175] are examples of surveillance systems that provide data on deaths from suicide. *NVSS* is a nationwide surveillance system that collects demographic, geographic, and cause-of-death data from death certificates.[7] *NVDRS* is a state-based surveillance system (currently in 40 states, the District of Columbia, and Puerto Rico) that combines data from death certificates, law enforcement reports, and coroner or medical examiner reports to provide detailed information on the circumstances of violent deaths, including suicide, which can assist communities in guiding prevention approaches.[175] Data from state and local Child Death Review teams[176] and Suicide Death Review Teams (which are in a few states) offer another source to identify deaths and obtain insight into the gaps in services, systems, and modifiable risk factors for suicide.



The *National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP)* provides nationally representative data about all types and causes of nonfatal injuries treated in U.S. hospital emergency departments, and can be used to assess national rates of, and trends in, self-harm injuries by cause (e.g., falls, poisoning, etc.), age, race/ethnicity, sex, disposition (where the injured person goes when released from the emergency department).[6]

In addition to information on deaths and nonfatal injuries, there are also surveillance systems that provide national, state, and some local estimates of suicidal behavior. The *Youth Risk Behavior Surveillance System (YRBSS)* collects information from a nationally representative sample of 9–12 grade students and is a key resource in monitoring health-risk behaviors among youth, including whether youth have seriously considered attempting suicide, attempted suicide, made a plan, or required treatment by a doctor or nurse for a suicide attempt that resulted in an injury, poisoning, or overdose.[177] The *YRBSS* data are obtained from a national school-based survey conducted by CDC as well as from state, territorial, tribal, and large urban school district surveys conducted by education and health agencies.[177] The *National Survey on Drug Use and Health (NSDUH)*[50] is an annual survey of the civilian, non-institutionalized population aged 12 years and older. *NSDUH* provides both national and state-level estimates of substance use (alcohol, tobacco, illicit drugs, and non-medical use of prescription drugs); mental health (past year mental illness, co-occurring illnesses); and service utilization, along with suicide ideation, suicide plans, and suicide attempts. *NSDUH* is a key resource to track trends in suicide-related risk factors in the population and to help identify groups at increased risk.[50]

It is also important at all levels (local, state, and federal) to address gaps in responses, track progress of prevention efforts and evaluate the impact of those efforts, including the impact of this technical package. Evaluation data, produced through program implementation and monitoring, is essential to provide information on what does and does not work to reduce rates of suicide and its associated risk and protective factors. Theories of change and logic models that identify short, intermediate, and long-term outcomes are an important part of program evaluation.

The evidence-base for suicide prevention has advanced greatly over the last few decades. However, additional research is needed to understand the impact of programs, policies, and practices on suicide (and suicide attempts, at a minimum), as opposed to merely examining their effectiveness on risk factors. More research is also needed to examine the effectiveness of primary prevention strategies (before risk occurs) and community-level strategies to prevent suicide at the population level. It will be important for researchers to test the effectiveness of combinations of the strategies and approaches included in this package. Most existing evaluations focus on approaches implemented in isolation, but there is potential to understand the synergistic effects within a comprehensive prevention approach. Lastly, there are also many potential opportunities to build and strengthen partnerships across program areas (e.g., violence prevention, substance abuse prevention) to evaluate the impact of different approaches on multiple outcomes.

Conclusion

Suicide is a serious public health problem. Rates of suicide have been on the rise for more than a decade and the costs stretch well into the billions of dollars each year. While suicide is a rare outcome statistically, its human impact has a ripple effect that is far-reaching. Each of us likely interacts with suicide survivors, those with lived experience, and those with thoughts of suicide on a daily basis—at home, at work, and in our communities. Suicide and suicide attempts are public health issues of societal concern. There are a number of barriers that have impeded progress, including, for example, stigma related to help-seeking, mental illness, being a survivor and fear related to asking someone about suicidal thoughts. Fortunately, like many public health problems, suicide is preventable,[1,5] and more is being done to prevent suicide than ever before, as evidenced by the work of the National Action Alliance for Suicide Prevention,[39,40,75,88] the release of the first world report on suicide,[5] and more timely surveillance data, to name just a few examples.

In an effort to continue pushing the field and society further towards prevention, this technical package includes strategies and approaches that ideally would be used in a comprehensive, multi-level and multi-sectoral way. It includes strategies and approaches to prevent the risk of suicide in the first place, as well as strategies focused on lessening the immediate and long-term harms of suicidal behavior. It includes strategies that range from a focus on the whole population regardless of risk to strategies designed to support people at highest risk. Importantly, this technical package extends the bounds of the typical prevention strategies to consider approaches that go beyond individual behavior change to better address risk factors impacting communities and populations more broadly (e.g., economic policies to strengthen housing and financial security).

While the evidence base continues to emerge, the collection of programs, policies, and practices laid out here are available for implementation now. In keeping with good public health practice, the intent is that monitoring and evaluation will play a key role in that implementation. Moreover, as new evidence becomes available, this technical package can be refined to reflect the current state of the science.

In closing, and in keeping with a message of resilience as spoken by those with lived experience, "hope, help, and healing is possible."





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Appendix: Summary of Strategies and Approaches to Prevent Suicide

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		Suicide	Suicide Attempts or Ideation	Other Risk/ Protective Factors for Suicide	
Strengthen economic supports	**Strengthening household financial security**				Government (local, state, Federal)
	Unemployment benefit programs	✓		✓	
	Other income supports	✓			Business/Labor
	Housing stabilization policies				Government (local, state, Federal)
	Neighborhood Stabilization Program			✓	
Strengthen access and delivery of suicide care	**Coverage of mental health conditions in health insurance policies**				Government (local, state, Federal) Healthcare Social Services
	Mental Health Parity Laws	✓		✓	
	Reduce provider shortages in underserved areas				
	National Health Service Corps (NHSC)			✓	
	Telemental Health (TMH)			✓	
	Safer suicide care through systems change				
	Henry Ford Perfect Depression Care (Pre-cursor to Zero Suicide)	✓		✓	
Create protective environments	**Reduce access to lethal means among persons at risk**				Government (local, state) Public Health Healthcare
	Intervening at suicide hot spots	✓			
	Safe storage practices		✓	✓	
	Emergency Department Counseling on Access to Lethal Means (ED CALM)			✓	
	Organizational policies and culture				Business/labor Justice Government (local, state, Federal)
	Together for Life	✓			
	US Air Force Suicide Prevention Program	✓		✓	
	Correctional suicide prevention	✓			
	Community-based policies to reduce excessive alcohol use				Government (local, state) Business/labor
	Alcohol outlet density	✓		✓	
Promote connectedness	**Peer norm programs**				Public Health Education
	Sources of Strength			✓	
	Community engagement activities				Public Health Government (local)
	Greening vacant urban spaces			✓	

*This column refers to the lead sectors well positioned to bring leadership and resources to implementation efforts. For each strategy, there are many other sectors such as non-governmental organizations that are instrumental to prevention planning and implementing specific activities.

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		Suicide	Suicide Attempts or Ideation	Other Risk/ Protective Factors for Suicide	
Teach coping and problem-solving skills	**Social-emotional learning programs**				Public Health Education
	Youth Aware of Mental Health Program		✓	✓	
	Good Behavior Game		✓	✓	
	Parenting skill and family relationship approaches				Public Health Education
	The Incredible Years			✓	
	Strengthening Families 10–14			✓	
Identify and support people at risk	**Gatekeeper training**				Public Health Health Care
	Applied Suicide Intervention Skills Training			✓	
	Garret Lee Smith Suicide Prevention Program	✓	✓		
	Crisis intervention				Public Health Social Services
	National Suicide Prevention Lifeline		✓	✓	
	Treatment for people at risk of suicide				Healthcare Social Services Justice
	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)		✓	✓	
	Collaborative Assessment and Management of Suicidality (CAMS)		✓	✓	
	Dialectical Behavioral Therapy (DBT)		✓	✓	
	Attachment-Based Family Therapy (ABFT)		✓		
	Translating Initiatives for Depression into Effective Solutions project (TIDES)			✓	
	Treatment to prevent re-attempts				Healthcare Social Services
	ED Brief Intervention with Follow-up Visits	✓			
	Active follow-up contact approaches	✓	✓		
	CBT for Suicide Prevention		✓		
Lessen harms and prevent future risk	**Postvention**				Healthcare
	StandBy Response Service		✓	✓	
	Safe reporting and message about suicide				Public Health Media
	Media Guidelines	✓			

*This column refers to the lead sectors well positioned to bring leadership and resources to implementation efforts. For each strategy, there are many other sectors such as non-governmental organizations that are instrumental to prevention planning and implementing specific activities.

For more information

To learn more about preventing child abuse and neglect, call 1-800-CDC-INFO or visit CDC's violence prevention pages at www.cdc.gov/violenceprevention.

National Center for Injury Prevention and Control
Division of Violence Prevention

AK2017

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Preventing Suicide:
A Technical Package of Policy, Programs, and Practices

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Centers for Disease Control and Prevention

2017

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Acknowledgments

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External Reviewers

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Overview

This technical package represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide. These strategies include: strengthening economic supports; strengthening access to mental health care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at-risk; and intervening to lessen harms and prevent future risk. The strategies represented in this package include those with a focus on preventing suicide from happening in the first place as well as approaches to lessen the immediate and long-term harms of suicidal behavior for individuals, families, communities, and society. The strategies in the technical package support the goals and objectives of the National Strategy for Suicide Prevention and the National Action Alliance for Suicide Prevention's priority to strengthen community-based prevention. Commitment, cooperation, and leadership from numerous sectors, including public health, education, justice, health care, social services, business, labor, and government can bring about the successful implementation of this package.

What is a Technical Package?

A technical package is a compilation of a core set of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome (Frieden, 2014). Technical packages help communities and states prioritize prevention activities based on the best available evidence. This technical package has three components. The first component is the ***strategy*** or the preventive direction or actions to achieve the goal of preventing suicide. The second component is the ***approach***. The approach includes the specific ways to advance the strategy. This can be accomplished through *programs, policies, and practices*. The approaches included come primarily from studies based in the United States. The ***evidence*** for each of the approaches in preventing suicide or its associated risk factors is included as the third component. This package is intended as a resource to guide and inform prevention decision-making in communities and states.

Preventing Suicide is a Priority

Suicide, as defined by the Centers for Disease Control and Prevention (CDC), is part of a broader class of behavior called *self-directed violence*. Self-directed violence refers to behavior directed at oneself that deliberately results in injury or the *potential* for injury (A.E. Crosby, Ortega, & Melanson, 2011). Self-directed violence may be *suicidal* or *non-suicidal* in nature. For the purposes of this document, we refer only to behavior where suicide is intended:

- **Suicide** is a death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

- **Suicide attempt** is defined as a *non-fatal* self-directed and potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Comment [A]: Add another sentence about LGBTQ youth?

Suicide is highly prevalent. Suicide presents a major challenge to public health in the United States and worldwide. It contributes to premature death, morbidity, lost productivity, and health care costs (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014). In 2014 (the most recent year of available death data), suicide was responsible for 42,773 deaths in the U.S., which is approximately one suicide every 12 minutes (Centers for Disease Control and Prevention, 2016). In 2014, suicide ranked as the 10th leading cause of death and has been among the top 12 leading causes of death since 1975 in the U.S (Centers for Disease Control and Prevention, 2016). Overall suicide rates increased 24% from 1999 to 2014 (Curtin, Warner, & Hedegaard, 2016). Suicide is a problem throughout the life span; it is the second leading cause of death among those aged 10–34 years; it is the fourth leading cause among persons in their 40s and seventh among persons in their 50s.

Suicide rates vary by race/ethnicity, age, and other population characteristics, with the highest rates across the lifespan occurring among non-Hispanic American Indian/Alaska Native (AI/AN) and non-Hispanic White population groups. In 2014, the rates for these groups were 17.8 and 16.4 per 100,000 population, respectively (Centers for Disease Control and Prevention, 2016c). Other population groups disproportionately impacted by suicide include middle-aged adults (whose rates increased 48% from 1999 to 2014, with steep increases seen among both males (43%) and females (63%) aged 45-64 years; Curtin et al., 2016); Veterans and other military personnel, whose suicide rate nearly doubled from 2003 to 2008, surpassing the rate of suicide among civilians for the first time in decades (Bachynski et al., 2012; Lineberry & O'Connor); and workers in certain occupational groups (e.g., protective service occupations; workers in farming, fishing, and forestry; McIntosh et al., 2016).

Suicides reflect only a portion of the problem (A.E. Crosby, Han, Ortega, Parks, & Gfroerer, 2011). Substantially more people are hospitalized as a result of nonfatal suicidal behavior (i.e. suicide attempts) than are fatally injured, and an even greater number are either treated in ambulatory settings (e.g., emergency departments) or not treated at all (A.E. Crosby, Han, et al., 2011). For example, during 2014, among adults aged 18 years and older, for every one suicide there were 9 adults treated in hospital emergency departments for self-harm injuries, 27 who reported making a suicide attempt, and over 227 who reported seriously considering suicide (i.e. ideation) (Ferdon et al., In press).

Suicide is associated with several risk and protective factors. Suicide, like other human behaviors, has no single determining cause. Instead, suicide occurs in response to multiple biological, psychological, interpersonal, environmental and societal influences that interact with one another, often over time. The social-ecological model – encompassing multiple levels of focus from the individual, relationship, community, and societal – is a useful framework for viewing and understanding suicide risk factors

identified in the literature (Dahlberg & Krug, 2002). Risk and protective factors for suicide exist at each level. For example, risk factors include:

- **Individual level**: History of depression and other mental illnesses, hopelessness, substance abuse, certain health conditions, previous suicide attempt, violence victimization and perpetration, and genetic and biological determinants
- **Relationship level**: High conflict or violent relationships, sense of isolation and lack of social support, family/loved one's history of suicide, financial and work stress
- **Community level**: Inadequate community connectedness, barriers to health care (e.g., lack of access to providers and medications)
- **Societal level**: Availability of lethal means of suicide, unsafe media portrayals of suicide, stigma associated with help-seeking and mental illness (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014).

It is important to recognize that the vast majority of individuals who are depressed, attempt suicide, or who have other risk factors noted, do *not* die by suicide. Furthermore, the relevance of each risk factor can vary by age, race, gender, sexual orientation, residential geography, and socio-cultural and economic status (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014).

Protective factors, or those influences that buffer against the risk for suicide, can also be found across the different levels of the social-ecological model. Protective factors identified in the literature include: effective coping and problem solving skills, moral objections to suicide, strong and supportive relationships with partners, friends, and family; connectedness to school, community, and other social institutions; availability of quality and ongoing physical and mental health care, and reduced access to lethal means (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014). These protective factors can either counter a specific risk factor or buffer against a number of risks associated with suicide.

Suicide is connected to other forms of violence. Exposure to violence (e.g., child abuse and neglect, bullying, peer violence, dating violence, sexual violence, and intimate partner violence) increases the risk of depression, post-traumatic stress disorder (PTSD), anxiety, suicide, and suicide attempts (Bossarte, Simon & Swahn, 2008; Chapman et al., 2004; Dube et al., 2001; Felitti et al., 1998; Klomek, Sourander, & Gould, 2010; Leeb, Lewis, & Zolotor, 2011; WHO, 2013). Women exposed to partner violence are nearly 5 times more likely to attempt suicide as women not exposed to partner violence (WHO, 2013). Exposure to adverse experiences in childhood, such as physical, sexual, emotional abuse and neglect, and living in homes with violence, mental health, substance abuse problems and other instability, increases the risk for suicide and suicide attempts several fold (Bellis et al., 2014; Dube et al., 2001). The psychosocial effects of violence in childhood and adolescence can be observed decades later, including severe problems with finances, family, jobs, and stress – factors that increase the risk for suicide. Suicide

Comment [A]: Bellis, M. A., Hughes, K., Leckenby, N., Jones, L., Baban, A., Kachaeva, M., Povilaitis, R., Pudule, I., Qirjako, G., Ulukol, B., Raleva, M., & Terzic, N. (2014). Adverse childhood experiences and associations with health-harming behaviors in young adults: surveys in the European Region. Bulletin of the World Health Organization, 92, 641–655B.

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Klomek, A. B., Sourander, A., & Gould, M. (2010).The association of suicide and bullying in childhood to young adulthood: A review of cross-sectional and longitudinal research findings. Canadian Journal of Psychiatry, 55(5), 282-288.

Leeb TR, Lewis T, Zolotor AJ. A review of physical and mental health consequences of child abuse and neglect and implications for practice. American Journal of Lifestyle Medicine, 2011; 5(5):454–468.

and other forms of violence often share the same individual, relationship, community, and societal risk factors suggesting that efforts to prevent interpersonal violence may also prove beneficial in preventing suicide (add citations). Further, just as risk factors may be shared across suicide and violence, so too may protective factors overlap. For example, connectedness to one's community (Kleiman, Riskind, Schaefer, & Weingarden, 2012), school (Carter, McGee, Taylor, & Williams, 2007), family (Maimon, Browning, & Brooks-Gunn, 2010), caring adults (Capaldi, Knoble, Shortt, & Kim, 2012; Losel & Farrington, 2012), and pro-social peers (Wyman et al., 2010) enhances resilience to suicide and other forms of violence.

Comment [A]: Wilkins N, Tsao B, Hertz M, Davis R, Klevens J. Connecting the dots: an overview of the links among multiple forms of violence. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (Atlanta, GA) and Prevention Institute, Oakland CA, 2014.

Haegerich TM, Dahlberg LL. Violence as a public health risk. American Journal of Lifestyle Medicine, 2011; 5(5):392-406.

Hamby S, Grych J. The web of violence: exploring connections among different forms of interpersonal violence and abuse. New York, NY: Springer Briefs in Sociology, 2013.

The health and economic consequences of suicide are substantial. Suicide and suicide attempts have far reaching consequences for individuals, families, and communities (Dunne, McIntosh, & Dunne-Maxim, 1987; Mishara, 1995; National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force, 2014; National Action Alliance for Suicide Prevention: Survivors of Suicide Loss Task Force, 2015). In an early study, Crosby and Sacks (2002) estimated that 7% of the U.S. adult population, or 13.2 million adults, knew someone in the prior 12 months who had died by suicide. They also estimated that for each suicide, 425 adults were exposed, or knew about the death. In a more recent study, in one state, Cerel et al (2016) found that 48% of the population knew at least one person who died by suicide in their lifetime. Research indicates that the impact of knowing someone who died by suicide and/or having lived experience (i.e., personally have attempted suicide, have had suicidal thoughts, or have been impacted by suicidal loss) is much more extensive than injury and death. People with lived experience may suffer long-term health and mental health consequences ranging from anger, guilt, and physical impairment, depending on the means and severity of the attempt (Chapman & Dixon-Gordon, 2007). Similarly, survivors of a loved one's suicide may experience ongoing pain and suffering including complicated grief (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004), stigma, depression, anxiety, post-traumatic stress disorder, and increased risk of suicidal ideation and suicide (Julie Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014; Sudak, Maxim, & Carpenter, 2008). Less discussed but no less important, are the financial and occupational effects for those left behind (Florence, Simon, Haegerich, Luo, & Zhou, 2015).

The economic toll of suicide is immense as well. According to conservative estimates, in 2013, suicide cost $50.8 billion in estimated lifetime medical and work-loss costs alone (Florence et al., 2015). Adjusting for potential under-reporting of suicide and drawing upon health expenditures per capita, GDP per capita, and variability among states in per capita health care expenditures and income, another study estimated the total lifetime costs associated with nonfatal injuries and deaths caused by self-directed violence to be approximately $93.5 billion in 2013 (Shepard, Gurewich, Lwin, Reed, & Silverman, 2016). The overwhelming burden of these costs were from lost productivity over the life course, with the average cost per suicide being over $1.3 million (Shepard et al., 2016). The true economic costs are likely higher as neither study included monetary figures related to other societal costs such as those associated with the pain and suffering of family members or other impacts.

Suicide can be prevented. Like most public health problems, suicide is preventable (U.S. Public Health Service, 1999). While progress will continue to be made into the future, evidence for numerous programs, practices, and policies currently exists, and many programs are ready to be implemented now. Just as suicide is not caused by a single factor, research suggests that reductions in suicide will not be prevented by any single strategy or approach (Silverman & Maris, 1995; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Rather, suicide prevention is best achieved by a focus across the individual, relationship, family, community, and societal-levels and across all sectors, private and public (e.g., business, public health, physical and behavioral healthcare, justice, education, and labor) (National Action Alliance for Suicide Prevention, 2014; World Health Organization, 2014).

Assessing the Evidence

This technical package includes programs, practices, and policies with evidence of impact on suicide or risk or protective factors for suicide. To be considered for inclusion in the technical package, the program, practice, or policy selected had to meet at least one of these criteria: a) meta-analyses or systematic reviews showing impact on suicide; b) evidence from at least one rigorous (e.g., randomized controlled trial [RCT] or quasi-experimental design) evaluation study that found significant preventive effects on suicide; c) meta-analyses or systematic reviews showing impact on risk or protective factors for suicide, or d) evidence from at least one rigorous (e.g., RCT or quasi-experimental design) evaluation study that found significant impacts on risk or protective factors for suicide. Finally, consideration was also given to the likelihood of achieving beneficial effects on multiple forms of violence; no evidence of harmful effects on specific outcomes or with particular subgroups; and feasibility of implementation in a U.S. context if the program, policy, or practice has been evaluated in another country.

Within this technical package, some approaches do not yet have research evidence demonstrating impact on rates of suicide but instead are supported by evidence indicating impacts on risk or protective factors for suicide (e.g., help-seeking, stigma reduction, depression, connectedness). In terms of the strength of the evidence, programs that have demonstrated effects on suicidal behavior (e.g., reductions in deaths, attempts) provide a higher-level of evidence, but the evidence base is not that strong in all areas. For instance, there has been less evaluation of community engagement and family programs on suicidal behavior. Thus, approaches in this package that have effects on risk or protective factors reflect the developing nature of the evidence base and the use of the best available evidence at a given time.

It is also important to note that there is often significant heterogeneity among the programs, policies, or practices that fall within one approach or strategy area in terms of the nature and quality of the available evidence. Not all programs, policies, or practices that utilize the same approach are equally effective, and even those that are effective may not work across all populations. Tailoring programs and more evaluation may be necessary to address different population groups. The evidence-based programs,

practices, or policies included in the package are not intended to be a comprehensive list for each approach, but rather to serve as examples that have been shown to impact suicide or have beneficial effects on risk or protective factors for suicide.

Context and Cross-Cutting Themes

One important feature of the package is the complementary, but potentially synergistic impact of the strategies and approaches. The strategies and approaches that have been included in this technical package represent different levels of the social ecology, with efforts intended to impact the community and societal levels, as well individual and relationship levels. The strategies and approaches are intended to work in combination and reinforce each other to prevent suicide (see box below). The strategies are arranged in order such that those strategies hypothesized to have the greatest potential for broad public health impact on suicide are included first, followed by those that might impact more select populations (e.g., persons who have already made a suicide attempt).

Preventing Suicide	
Strategy	**Approach**
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access to mental health care	• Coverage of mental health conditions in health insurance policies
Create protective environments	• Reducing access to lethal means among persons at-risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm approaches • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning programs • Parenting skill and family relationship approaches
Identify and support people at risk	• Gatekeeper training • Screening combined with care management • Crisis intervention
Intervene to lessen harms and prevent future risk	• Treatment for people at-risk of suicide • Treatment to prevent re-attempts • Postvention • Safe reporting following a suicide

It is important to note that examples listed under one strategy may also be relevant to another strategy. For instance, some forms of crisis intervention, an approach under *Identify and Support People At-Risk*,

Comment [A]: A few other things that could be mentioned:

The SV package included the following paragraph:

"The strategies and approaches delineate prevention efforts that impact various SV related outcomes. The strategies are not mutually exclusive categories, but each has an immediate focus. The strategy Create Protective Environments, for example, may ultimately impact SV social norms, but the immediate focus of this strategy is to change school, workplace and community environmental factors. Similarly, the approaches within any one strategy sometimes have components that cross other strategies. For example, Mobilizing Men and Boys as Allies, an approach in the Promote Social Norms that Protect against Violence strategy, includes fostering healthy dating relationships which is also found in some of the approaches under the Teach Skills to Prevent SV strategy."

may also be considered under *Intervene to Lessen Harms and Prevent Future Risk*. Social emotional learning programs, an approach under the *Teach Coping and Problem-Solving Skills* strategy, sometimes include components to change peer norms and the broader environment. The goal of this package is to stress the importance of comprehensive prevention efforts and to provide examples of effective programs addressing each level of the social ecology, with the knowledge that some programs, practices, and policies may impact multiple levels. Further, those that involve multiple sectors and impact multiple levels of the social ecology are more likely to have a greater impact on the overall burden of suicide.

Suicide ideation, thoughts, attempts, and deaths vary by gender, race/ethnicity, age, occupation, and other important population characteristics. Further, certain transition periods are also associated with higher rates of suicide (e.g., transition from working into retirement, transition from active duty military status to civilian status). In fact, suicide risk can change along with dynamic risk factors. For example, individuals' coping skills may change during periods of crisis and heightened stress, limiting their normal ability to effectively solve problems and cope. Research indicates that suicide risk changes as a result of the number and intensity of key risk and protective factors experienced (Turecki, 2014). Ideally, the availability of multiple strategies and approaches tailored to the social, economic, cultural, and environmental context of individuals and communities are desirable as they may increase the likelihood of removing barriers to supportive and effective care and provide opportunities to develop individual and community resilience.

Identifying programs, practices, and policies with evidence of impact on suicide, suicide attempts, or beneficial effects on risk or protective factors for suicide is only the first step. In practice, the effectiveness of the programs, policies and practices identified in this package will be strongly dependent on how well programs are implemented as well as the partners and communities in which they are implemented. Practitioners in the field may be in the best position to assess the needs and strengths of their communities and work with community members to make decisions about the combination of approaches included here that are best suited to their context.

Data-driven strategic planning processes can help communities with this work (e.g., see Hawkins, Catalano, & Kuklinski, 2014; Edwards et al., 2000; Plested, Edwards, & Jumper-Thurman, 2006). These planning processes engage and guide community stakeholders through a prevention planning process designed to address a community's profile of risk and protective factors with evidence-based programs, practices, and policies. These processes can also be used to monitor implementation, track outcomes, and make adjustments as indicated by the data. The readiness of the program for broad dissemination and implementation (e.g., availability of program materials, training and technical assistance) can also influence program effects. Implementation guidance to assist practitioners, organizations and communities will be developed separately.

This package includes strategies where public health agencies are well positioned to bring leadership and resources to implementation efforts. It also includes strategies where public health can serve as an

Comment [A]: Edwards, R. W., Jumper-Thurman, P., Plested, B., Oetting, E. R., & Swanson, L. (2000). Community readiness: research to practice. Journal of Community Psychology, 28(3), 291–307.

Plested, B. A., Edwards, R. W., & Jumper-Thurman, P. (2006). Community Readiness: A Handbook for Successful Change. Fort Collins, CO: Tri-Ethnic Center for Prevention Research.

important collaborator (e.g., strategies addressing community and societal level risks), but where leadership and commitment from other sectors such as business, labor or health care is critical to implement a particular policy or program (e.g., workplace policies; screening combined with care management). The role of various sectors in the implementation of a strategy or approach in preventing suicide is described further in the section on *Sector Involvement*.

In the sections that follow, the strategies and approaches with the best available evidence for preventing suicide are described.

DRAFT

Strengthen Economic Supports

Rationale

Studies from the U.S. examining historical trends indicate that suicide rates increase during economic recessions marked by high unemployment rates, job losses, and economic instability and decrease during economic expansions and periods marked by low unemployment rates, particularly for working-age individuals 25 to 64 years old (Luo et al., 2011; Fowler et al., 2015). Economic and financial strain, such as job loss, long periods of unemployment, reduced income, difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress may increase an individual's risk for suicide or may indirectly increase risk by exacerbating related physical and mental health problems; buffering these risks can therefore, potentially protect against suicide (Stack & Wasserman, 2007). For example, strengthening economic support systems can help people stay in their homes or obtain affordable housing while also paying for necessities such as food and medical care, job training, child care, among other expenses required for daily living. In providing this support, stress and anxiety and the potential for a crisis situation may be reduced, thereby preventing suicide. Although more research is needed to understand how economic factors interact with other factors to increase suicide risk, the available evidence suggests that strengthening economic supports may be one opportunity to buffer suicide risk.

Approaches

Economic supports for individuals and families can be strengthened by targeting household financial security and ensuring stability in housing during periods of economic stress.

- **Strengthening household financial security** can potentially buffer the risk of suicide by providing individuals with the financial means to lessen the stress and hardship associated with a job loss or other unanticipated financial problems. The provision of unemployment benefits and other forms of temporary assistance, livable wages, medical benefits, and retirement and disability insurance to help cover the cost of necessities or to offset costs in the event of disability, are examples of ways to strengthen household financial security.

- **Housing stabilization policies** aim to keep people in their homes and provide housing options for those in need during times of financial insecurity. This may occur through programs that provide affordable housing such as through government subsidies or through other options available to potential homebuyers such as loan modification programs, move-out planning, or financial counseling services that help minimize the risk or impact of foreclosures and eviction.

Potential Outcomes

- Reductions in suicide rates

- Reductions in foreclosure rates
- Reductions in eviction rates
- Reductions in emotional distress

Evidence

There is evidence suggesting that strengthening household financial security and stabilizing housing can reduce suicide risk.

- **Strengthen household financial security.** The *Federal-State Unemployment Insurance Program* allows states to define the maximum amount and duration of unemployment benefits that workers are entitled to receive after a job loss (Cylus, Glymour, & Avendano, 2014). An examination of variations in *unemployment benefit programs* across states demonstrated that the impact of unemployment on rates of suicide was offset in those states that provided greater than average unemployment benefits (mean level: $7,990 per person in U.S. constant dollars;(Cylus, Glymour, & Avendano, 2014). The effects of *unemployment benefit programs* were also consistent by sex and age group. Another U.S. study examining the link between unemployment and suicide rates using monthly suicide data, length of unemployment (less than 5 weeks, 5-14 weeks, 15-26 weeks, and greater than 26 weeks), and job losses found that the duration of unemployment, as opposed to just the loss of job, predicted suicide risk (Classen & Dunn, 2012). Together, these results suggest that not only should state unemployment benefit programs be generous in their financial allocations, but also in their duration.

  Other measures to strengthen household financial security (e.g., transfer payments related to retirement and disability insurance, unemployment insurance compensation, medical benefits, and other forms of family assistance) have also shown an impact on rates of suicide. A study by Flavin and Radcliff (2009) examined the impact of states' per capita spending on transfer payments, medical benefits, and family assistance (Temporary Assistance to Needy Families – TANF) and total state spending on suicide rates between 1990-2000, controlling for a number of suicide risk factors (e.g., residential mobility, divorce rate, unemployment rate) at the state level. As per capita spending on total transfer payments, medical benefits, and family assistance increased there was an associated decrease in state suicide rates. Moreover, it wasn't spending in general that was associated with the reduction but spending on these types of assistance. In terms of lives saved, Flavin & Radcliff calculated the cost of reducing a state's suicide rate by a full point for the years studied. At the national level, they estimated that 3,000 fewer suicides would occur per year nationwide if every state increased its per capita spending on these types of assistance by $45 per year (Flavin & Radcliff, 2009). Although this was a correlational study, the results demonstrate the potential benefits of policies that reach particularly vulnerable

individuals during periods of great need and increased risk for suicide. More evaluation studies are needed to further understand the outcomes impacted by programs such as these.

- **Housing stabilization policies.** The *National Neighborhood Stabilization Program* was designed to help neighborhoods suffering from high rates of foreclosure and abandonment by slowing the deterioration of the neighborhoods and providing affordable housing options for low, moderate, and middle-income homebuyers. This program also offers financial assistance to eligible individuals for the purchase of a new home. Although this program has not been rigorously evaluated for its impact on suicide outcomes, it addresses foreclosure and eviction, which are risk factors for suicide. A longitudinal analysis of annual data on suicides and foreclosures demonstrated that as the proportion of foreclosed properties increased in U.S. states, so did the state suicide rate, particularly among working-aged adults (Houle & Light, 2014). Another study of data from 16 U.S. states participating in the National Violent Death Reporting System found that suicides precipitated by home foreclosures and evictions increased more than 100% from 2005 (before the housing crisis began) to 2010 (after it had peaked; Fowler, Gladden, Vagi, Barnes, and Frazier (2015)). Most of these suicides occurred prior to the actual loss of the decedent's home. These findings suggest that integrating suicide prevention resources, messaging, and referrals into financial, foreclosure, and move-out planning and counseling services may help to prevent suicide.

Comment [A]: Per Richard McKeon's comment, looking into whether there's any info on the effectiveness of housing for those with mental illness...

Strengthen Access to Mental Health Care

Rationale

While most people with mental health problems do not attempt or die by suicide (Olfson, Gerhard, Huang, Crystal, & Stroup, 2015; Owens, 2002), and the level of risk conferred by different types of mental illness varies (Arsenault-Lapierre, Kim, & Turecki, 2004; E. C. Harris & Barraclough, 1997; Tyrer, Reed, & Crawford, 2015), previous research indicates that mental illness is an important risk factor for suicide (E. C. Harris & Barraclough, 1998; World Health Organization, 2014). State-level suicide rates have also been found to be correlated with general mental health measures such as depression (Lang, 2013; Mark, Shern, Bagalman, & Cao, 2007). Findings from the National Comorbidity Survey indicate that relatively few people in the U.S. with mental health disorders receive treatment for those conditions (Kessler et al., 2005). Lack of access to mental health care is one of the contributing factors related to the underuse of mental health services (Cunningham, 2009). Identifying ways to improve access to timely, affordable, and quality mental health care for people in need is a critical component to suicide prevention (World Health Organization, 2014). Apart from the treatment benefits, it can also serve to normalize help-seeking behavior and increase the use of such services.

Approaches

One approach to strengthening access to mental health care is through the provision of mental health coverage in health insurance policies. Attending to training and provider shortages is another approach.

- **Coverage of mental health conditions in health insurance policies.** Federal and state laws include provisions for equal coverage of mental health services in health insurance plans that is on par with coverage for other health concerns (i.e., mental health parity). Benefits and services covered include such things as the number of visits, co-pays, deductibles, inpatient/outpatient services, prescription drugs, and hospitalizations. If a state has a stronger mental health parity law than the federal parity law, then insurance plans regulated by the state must follow the state parity law. If a state has a weaker parity law than the federal parity law (e.g., includes coverage for some mental health conditions but not others), then the federal parity law will replace the state law. Equal coverage does not necessarily imply good coverage as health insurance plans vary in the extent to which benefits and services are offered to address various health conditions. Rather it helps to ensure that mental health services are covered on par with other health concerns.

- **Improve training and access to mental health care providers.** Access to effective and contemporary mental health care is largely dependent upon the training and the size of the mental health care workforce available to provide quality care. Over 85 million Americans live in areas with an insufficient number of mental health providers; this shortage is particularly severe among low-income urban and rural communities (U.S. Department of Health and

Comment [A]: This word sticks out to me. Could delete in order to avoid questions about what contemporary care means—unless we know and want to state but guessing we don't. Or maybe say –state-of-the-art??

Human Services Health Resources and Services Administrations, 2016). Approaches that ~~can~~ increase the number and distribution of practicing mental health providers include: providing and expanding existing state and federal programs and training (?) for providers, increasing wages and reimbursement rates for mental health services, adopting collaborative care models, and expanding telemental health services. Such approaches can increase the likelihood that those in need will be able to access affordable, quality care for mental health problems, which can reduce risk for suicide.

Comment [A]: Love this paragraph. My only comment (except for the one above ?!) is that the approach says "Improve training…" but the text is focused exclusively on access. Might want to insert another mention of 'training' (explicitly). Could insert after federal programs and training for providers…

Potential Outcomes

- Increases in utilization of mental health services
- Reductions in symptoms of mental illnesses
- Reductions in rates of suicide attempts
- Reductions in rates of suicide

Evidence

There is evidence suggesting that coverage of mental health conditions in health insurance policies can reduce risk factors associated with suicide and may directly impact suicide rates.

- **Coverage of mental health conditions in health insurance policies.** The National Survey of Drug Use and Health is a nationally representative survey of the U.S. population that provides data on substance use, mental health conditions, and services utilization. Using data from this survey, K. M. Harris, Carpenter, and Bao (2006) found that 12 months after states enacted *mental health parity laws*, self-reported use of mental healthcare services significantly increased. Moreover, subsequent research by Lang (2013) examined state mental health laws and suicide rates between 1990 and 2004 and found that mental health parity laws, specifically, were associated with an approximate 5% reduction in suicide rates. This reduction, in the 29 states with parity laws, equated to the prevention of 592 suicides per year (Lang, 2013).

- **Improve training and access to mental health care providers.** One example of a program to improve access to mental health care providers is the *National Health Service Corps (NHSC)*, which offers financial incentives to attract mental/behavioral health clinicians to underserved areas. Programs such as ~~*this*~~ *NHSC* encourage individuals to work in the mental health profession in locations designated as ~~a~~ Health Professional Shortage ~~A~~areas (HPSAs) in exchange for student loan debt repayment. A 2012 retention survey conducted by the Health Resources and Services Administration (HRSA), found that 61% of mental and behavioral health care providers continued to practice in designated mental health shortage areas after their four year commitment to The National Health Service Corps (U.S. Department of Health and Human Services Health Resources and Services Administration, 2016). *NHSC* is made possible by Title

VII (Section 747, Primary Care Training) funding which improves the educational infrastructure of medical schools and residency programs to encourage physicians to work with underserved populations. ~~Additionally, from 2003 to 2008, Title VII Section 747 Primary Care Training Grant funds were reduced by almost 50% from $92 million per year to $48 million. Title VII grants are aimed at improving the educational infrastructure of medical schools and residency programs to encourage physicians to work with underserved populations.~~ Using data ~~on Title VII grant awards~~ from ~~HRSA's Bureau of Health Professions in combination with data from~~ the 2004 American Medical Association's Physician Masterfile and from Medicare claims ~~data~~ data~~listing the treating physician, an evaluation~~one study of the impact ~~of Title VII training programs on physicians' participation in the *National Health Service Corps* and staffing of community health centers, which provide primary care services for underserved groups,~~ demonstrated that attending a medical school or residency program that received Title VII training was positively associated with both participation in the NHSC loan repayment program and with staffing of community health centers serving underserved populations ~~as well as service in CHCs~~ (Rittenhouse et al., 2008). While this evaluation focused on the commitment of primary care physicians to these programs, examination of the impact of such programs ~~aimed at~~on ~~improving~~ improved care in underserved settings, among specialty physicians, such as psychiatrists, is still needed. Moreover, between 2003 and 2008, Title VII funds were reduced by almost 50%-- from $92 million per year to $48 million, so additional study on the programs impact is needed.

Telemental health (TMH) services refer to the use of telephone, video and ~~other~~ web-based technologies for providing psychiatric or psychological care at a distance. TMH can be used in a ~~wide range~~variety of settings (e.g. ~~including~~ outpatient clinics, hospitals, ~~schools, and~~ military treatment facilities) to treat a wide range of ~~ing a number of~~ mental health conditions, ~~such as depression, post-traumatic stress disorder, and evidence-based psychotherapy~~. TMH can ~~enhance~~ improve access to care for patients in isolated areas as well as reduce travel time and expenses, reduce delays in receiving care, and improve satisfaction interacting with the mental health care system. A systematic review of TMH ~~services foundservices~~ found that services rated as high or good quality ~~found that there was evidence ofwere~~ associated with effectiveness ~~for TMH~~ in treating mental health conditions such as depression, schizophrenia, ~~postratumatic stress, panic disorders,~~ substance abuse, and suicide (attempts? Deaths?) among other outcomes (Hailey, Roine, & Ohinmaa, 2008). Further, Mohr and colleagues (2008) conducted a meta-analysis examining the effect of psychotherapy delivered specifically via telephone and found that it significantly reduced depressive symptoms in comparison to ~~patients enrolled in~~ face-to-face psychotherapy. They also found that treatment attrition rates were significantly lower among patients receiving telephone-administered psychotherapy ~~patients~~ compared to patients receiving face-to-face therapy ~~patients~~. Thus, TMH may not only

Comment [A]: Can we take this out??

Comment [A]: I think this is grammatically correct but I'd recommend shortening.

Comment [A]: Is this right? just tacked that on. Make sure this is what you intended.

Comment [A]: I may have changed this! is this correct?

offer improved access to mental health care, but it may also ensure continuity of care, and thereby further reduceing the risk for suicide.

Finally, collaborative care models deliver mental health and medical care to patients with mental health conditions in primary care settings. The VA TIDES (Veterans Affairs Translating Initiatives for Depression into Effective Solutions) pProject, called VA TIDES, is an example of a collaborative care model that uses a depression care liaison to link primary care and mental health careservices. The depression care liaison assesses and educates patients, and follows up with both patients and providers between primary care visits to optimize treatment. Collaborative care increases the efficiency of providing mental health care services and also by bringing (?)brings mental health care care to the primary care setting, where most patients are first detected and subsequently treated for many mental health conditions, including depression. Meta-analyses have demonstrated that collaborative care models are effective in treating mental health conditions, including such as depression, across age, sex, and racial/ethnic backgrounds (Archer et al., 2012; Gilbody, Bower, Fletcher, Richards, & Sutton, 2006). A study of tThe VA TIDES project, specifically, found significant improvements (decreases?) in depression severity scores among 70% of primary care patients. TIDES also demonstrated 85% and 95% compliance with medication and follow-up visits, respectively (Rubenstein et al., 2010).

DRAFT

Create Protective Environments

Rationale

Prevention efforts that focus not only on individual behavior change (e.g., help-seeking, treatment interventions) but on changes to the environment can increase the likelihood of positive behavioral and health outcomes (Haddon, 1980). Creating environments that address risk and protective factors where individuals live, work, and play, can help prevent suicide (Dahlberg & Krug, 2002; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). For example, rates of suicide are high among middle-aged adults (who comprise 42.6% of the workforce) and are also elevated in certain occupational groups (e.g., farming, fishing, forestry, and construction; Han et al., 2016; McIntosh et al., 2016). Thus, workplaces may serve as an ideal setting for reaching certain high-risk groups and implementing programs, practices and policies to buffer against suicide. Changes to organizational culture through the implementation of supportive policies, for instance, can change social norms, encourage help-seeking, and demonstrate that good health and mental health are valued and that stigma and other risk factors for suicide are not (Knox et al., 2010; National Action Alliance for Suicide Prevention Workplace Task Force, 2015). Similarly, modifying the characteristics of the environment to prevent harmful behavior such as access to lethal means can reduce suicide rates, particularly in times of crisis (Beautrais, Gibb, Fergusson, Horwood, & Larkin, 2009; A.E. Crosby, Espitia-Hardeman, Ortega, & Lozano, 2013; Kaplan et al., 2013; Miller, Warren, Hemenway, & Azrael, 2015; Runyan et al., 2016).

Comment [A]: Not sure whether to keep or drop the clause about the % of the workforce. It comes from the following link and is the combined percentage for those aged 35-54.

http://www.bls.gov/emp/ep_table_304.htm

Approaches

The current evidence suggests three potential approaches for creating environments that protect against suicide.

- **Reducing access to lethal means among persons at-risk of suicide.** Means of suicide such as firearms, hanging/suffocation, or jumping from heights provide little opportunity for rescue and, as such, have high case fatality rates (e.g., about 85% of people who use a firearm in a suicide attempt will die from the injury). Research also indicates that 1) the interval between deciding to act and attempting suicide can be as short as 5 or 10 minutes (Deisenhammer et al., 2009; Simon et al., 2001) and 2) that people tend *not* to substitute a different method when a highly lethal method is unavailable or difficult to access (Hawton, 2007; Yip et al., 2012). Therefore, increasing the time interval between deciding to act and the suicide attempt, for example, by making it more difficult to access lethal means, can be lifesaving. The following are examples of approaches reducing access to lethal means for persons at-risk of suicide:

    - *Intervening at Suicide Hotspots.* Suicide hotspots, or places where suicides may take place relatively easily, include tall structures (e.g., bridges, cliffs, balconies, and rooftops),

railway tracks, and isolated locations such as parks. Efforts to prevent suicide at these locations include erecting barriers or limiting access to prevent jumping and installing signs and telephones to encourage individuals who are considering suicide, to seek help (Cox et al., 2013).

- *Safe Storage Practices.* Safe storage of medications, firearms, and other household products can reduce the risk for suicide by separating vulnerable individuals from easy access to lethal means. Such practices may include education and counseling around storing firearms--locked in a secure place (e.g., in a gun safe or lock box), unloaded and separate from the ammunition--and keeping medicines in a locked cabinet or other secure location away from people who may be at risk or who have made prior attempts (Rowhani-Rahbar, Simonetti, & Rivara, 2016; Runyan et al., 2016).

- **Organizational policies and culture** that promote protective environments may be implemented in places of employment. Such policies and cultural values may promote prosocial behavior (e.g., asking for help), skill building, changing social norms, referral and access to helping services (e.g. mental health, substance abuse treatment, financial counseling), and encourage leadership support from the top down. Such policies and cultural shifts can positively impact organizational climate and morale and help prevent suicide and its related risk factors (e.g. depression, social isolation) (National Action Alliance for Suicide Prevention Workplace Task Force, 2015).

- **Community-based policies to reduce excessive alcohol use.** Research studies in the United States have found that greater alcohol availability is positively associated with alcohol-involved suicides (Escobedo & Ortiz, 2002; Giesbrecht et al., 2015). Policies to reduce excessive alcohol use broadly include zoning to limit alcohol outlet locations and density, taxes on alcohol, and bans on the sale of alcohol for individuals under the legal drinking age. These policies are important because acute alcohol use has been found to be associated with more than one-third of suicides and approximately 40% of suicide attempts (Cherpitel, Borges, & Wilcox, 2004).

Potential Outcomes

- Increases in safe storage of means
- Reductions in suicide attempts
- Reductions in suicide deaths
- Increases in help-seeking
- Reductions in alcohol-related suicide deaths

Evidence

The evidence suggests that creating protective environments can reduce suicide and suicide attempts and increase protective behaviors.

- **Reducing access to lethal means among persons at-risk of suicide.** A meta-analysis examining the impact of *suicide hotspot interventions* implemented in combination or in isolation, both in the U.S. and abroad, found associated reduced rates of suicide (Cox et al., 2013; Pirkis et al., 2015). For example, after erecting a barrier on the Jacques-Cartier bridge in Canada, the suicide rate from jumping from the bridge decreased from about 10 suicide deaths per year to about 3 deaths per year (Perron, Burrows, Fournier, Perron, & Ouellet, 2013). Moreover, the reduction in suicides by jumping was sustained even when all bridges and nearby jumping sites were considered, suggesting little to no displacement of suicides to other jumping sites (Perron et al., 2013). Further evidence for the effectiveness of bridge barriers was demonstrated by a study examining the impact of the *removal* of safety barriers from the Grafton Bridge in Auckland, New Zealand. After removal of the barrier, both the number and rate of suicide increased fivefold (Beautrais, 2001; Beautrais et al., 2009).

  Another form of means reduction involves implementation of *safe storage practices*. In a case-control study of firearm-related events identified from 37 counties in Washington, Oregon, and Missouri, and from 5 trauma centers, Grossman et al. (2005) found that storing firearms unloaded, separate from ammunition, in a locked place or secured with a safety device was protective of suicide attempts among adolescents. Further, a recent systematic review of clinic and community-based education and counseling interventions suggested that the provision of safety devices significantly increased safe firearm storage practices compared to counseling alone or compared to the provision of economic incentives to acquire safety devices on one's own (Rowhani-Rahbar et al., 2016).

  Another program, The *Emergency Department Counseling on Access to Lethal Means (ED CALM)*, trained psychiatric emergency clinicians in a large children's hospital to provide lethal means counseling and safe storage boxes to parents of patients under age 18 receiving care for suicidal behavior. In a pre-post quality improvement project, Runyan et al (2016) found that at post-test 76% (of the 55% of parents followed up, n=114) reported that all medications in the home were locked up as compared to fewer than 10% at the time of the initial emergency department visit. Among parents who indicated the presence of guns in the home at pre-test (i.e. 67%), all (100%) reported guns were currently locked up at post-test (Runyan et al., 2016).

- **Organizational policies and culture.** *Together for Life* is a workplace program of the Montreal Police Force implemented to address suicide among officers. Policy and program components

were designed to foster an organizational culture that promoted mutual support and solidarity among all members of the Force. The program included training of supervisors, managers and all units to improve competencies in identifying suicidal risk and to improve use and awareness of existing resources. The program also included an education campaign to improve awareness and help-seeking (Mishara & Martin, 2012). Police suicides were tracked over 12 years and compared to rates in the control city of Quebec. The suicide rate in the intervention group decreased significantly by 78.9% to a rate of 6.4 suicides per 100,000 population per year compared to an 11% increase in the control city (29.0 per 100,000) (Mishara & Martin, 2012).

Another example of this approach is the *United States Air Force Suicide Prevention Program.* The program included 11 policy and education initiatives and was designed to change the culture of the Air Force surrounding suicide. The program uses leaders as role models and agents of change, establishes expectations for behavior related to awareness of suicide risk, develops population skills and knowledge (i.e., education and training), and investigates every suicide (i.e., outcomes measurement). The program represents a fundamental shift from viewing suicide and mental illness solely as medical problem and instead sees them as larger service-wide problems impacting the whole community (Knox, Litts, Talcott, Feig, & Caine, 2003). Using a time-series design to examine the impact of the program on various violence-related outcomes, researchers found that the program was associated with a 33% relative risk reduction in suicide (Knox et al., 2003).The program was also associated with relative risk reductions in related outcomes including moderate and severe family violence (30% and 54%, respectively), homicide (51%), and accidental death (18%) (Knox et al., 2003). A longitudinal assessment of the program over the period 1981 to 2008 (16 years before the 1997 launch of the program and 11 years post-launch) found significantly lower rates of suicide after the program was launched than before (Knox et al., 2010). These effects were sustained over time, except in 2004, which the authors found was associated with less rigorous implementation in that year than in the other years (Knox et al., 2010).

- **Community-based policies to reduce excessive alcohol use.** While multiple policies to limit excessive use of alcohol exist, several studies on alcohol outlet *density*, specifically, suggest that measures to reduce alcohol outlet density can potentially reduce alcohol-involved suicides. Additionally, a longitudinal analysis of alcohol outlet density, suicide mortality, and hospitalizations for suicide attempts over 6 years in 581 California zip codes indicated that the density of bars, specifically, is related to suicide and suicide attempts, particularly in rural areas (Johnson, Gruenewald, & Remer, 2009).

DRAFT

Promote Connectedness

Rationale

Sociologist, Emile Durkheim theorized in 1897 that weak social bonds, i.e. lack of connectedness, are among the chief causes for suicidality (Durkheim, 1897/1951). *Connectedness* is the degree to which an individual or group of individuals are socially close, interrelated, or share resources with others (Centers for Disease Control and Prevention, 2009). Social connections can be formed within and between multiple levels of the social ecology (Dahlberg & Krug, 2002), for instance between individuals (e.g. peers, neighbors, co-workers), families, schools, neighborhoods, workplace, faith communities, cultural groups, and society as a whole. Related to connectedness, *social capital* refers to a sense of trust in one's community and neighborhood, social integration, and also the availability and participation in social organizations (Beyer, Layde, Hamberger, & Laud, 2015; Muennig, Cohen, Palmer, & Zhu, 2013). Many ecological cross-sectional and longitudinal studies have examined the impact of aspects of social capital on depression symptoms, depressive disorder, mental health more generally, and suicide. While the evidence is limited, existing studies suggest the pattern is towards a positive association between social capital measured by social trust, community/neighborhood engagement, and improved mental health. Connectedness and social capital together can serve to protect against suicidal behaviors by decreasing isolation, encouraging adaptive coping behaviors, increasing belongingness, personal value and worth all of which helps individuals to build resilience in the face of adversity. Connectedness can also provide individuals with better access to formal supports and resources, mobilize communities to meet the needs of its members and provide collective primary prevention activities to the community as a whole (Centers for Disease Control and Prevention, 2009).

Approaches

Promoting connectedness among individuals and within communities through modeling peer norms and enhancing community engagement may protect against suicide.

- **Peer norm approaches** seek to normalize protective factors for suicide such as help-seeking, reaching out and talking to trusted adults, and promote peer connectedness. By leveraging the leadership qualities and social influence of peers, these approaches can be used to shift group-level beliefs and promote positive social and behavioral change. These approaches typically target youth and are delivered in school settings but can also be implemented in community settings.

- **Community engagement activities**. Community engagement is an aspect of social capital. Community engagement approaches may involve residents participating in a range of activities, including religious activities, community clean-up and greening activities, and physical exercise. These activities provide opportunities for residents to become more involved in the community and to connect with other community members, organizations, and resources, resulting in

enhanced overall physical health, reduced stress, and decreased depressive symptoms, thereby reducing risk of suicide.

Potential Outcomes

- Reductions in maladaptive coping attitudes and behaviors
- Increases in healthy coping attitudes and behaviors
- Increases in referrals for youth in distressed
- Increases help-seeking behaviors
- Increases in positive perceptions of adult support

Evidence

Current evidence suggests a number of positive benefits of peer norm and community engagement activities, although more evaluation research is needed to examine whether these improvements in factors that protect against suicidal behavior translate into reduced suicide attempts and deaths.

- **Peer norm approaches.** Evaluations show that programs such as *Sources of Strength* can improve school norms and beliefs about suicide that are created and disseminated by student peers. In a randomized controlled trial of *Sources of Strength* conducted with 18 high-schools (6 metropolitan, 12 rural), Wyman et al. (2010) found that the program improved adaptive norms regarding suicide among peer leaders, connectedness to adults, and school engagement. Peer leaders were also more likely than controls to refer a suicidal friend to an adult. For students, the program resulted in increased perceptions of adult support for suicidal youths, particularly among those with a history of suicidal ideation, and the acceptability of help-seeking behaviors. Finally, trained peer leaders also reported a greater decrease in maladaptive coping attitudes compared with untrained leaders (Wyman et al., 2010).

- **Community engagement activities.** A vacant lot greening initiative was undertaken in Philadelphia between 1999 and 2008. Local residents and community members worked together to green 4,436 lots (or 7.8 million square feet) in 4 areas of the city. Researchers found significant reductions in community residents' self-reported level of stress, which is a risk factor for suicide, and engagement in more physical exercise, a protective factor for suicide, than residents in control vacant lot areas. Other benefits included reductions in firearm assaults and vandalism (Branas et al., 2011).

Teach Coping and Problem-Solving Skills

Rationale

Building life skills prepares individuals to successfully tackle every day challenges and adapt to stress and adversity. Life skills encompasses many concepts, but most often include coping and problem-solving skills, emotional regulation, conflict resolution, and critical thinking. Life skills are important in shielding individuals from suicidal behaviors (World Health Organization, 2014). Suicide prevention programs that focus on life and social skills training are drawn from social cognitive theories (Bandura, 1986), surmising that suicidal behavior is attributed to either direct learning and modeling or environmental and individual (e.g. hopelessness) characteristics. The inability to employ adequate strategies to cope with immediate stressors or identify and find solutions for problems has been characterized among suicide attempters (Pollock & Williams, 2004). Teaching and providing youth with the skills to tackle every day challenges and stressors is, therefore, an important component to suicide prevention.

Approaches

Social emotional learning programs and parenting skill and family relationship programs are two approaches for teaching coping and problem-solving skills.

- **Social emotional learning programs** focus on developing and strengthening communication and problem-solving skills, emotion regulation, conflict resolution, help seeking and coping skills. These approaches address a range of risk and protective factors for suicidal behavior. They provide children and youth with skills to resolve problems in relationships, school, and with peers, and help youth to address other negative influences (e.g., substance use) associated with suicide. These approaches are typically delivered to all students in a particular grade or school, although some programs also focus on groups of students considered to be at high risk for suicide. Opportunities to practice and reinforce skills are an important part of programs that work (Herman, Borden, Reinke, & Webster-Stratton, 2011).

- **Parenting skill and family relationship programs** provide caregivers with support and are designed to strengthen parenting skills, enhance positive parent-child interactions, and improve children's behavioral and emotional skills and abilities. Programs are typically designed for parents or caregivers with children in a specific age range and can be self-directed or delivered to individual or groups of families. Some programs have sessions primarily with parents while others include sessions for parents, youth, and the family. Specific program content typically varies by the age of the child but often has consistent themes of child development, parent-child communication and relationships, and youth's interpersonal and problem-solving skills.

Potential Outcomes

- Reductions in suicide attempts and suicide ideation
- Reductions in suicide risk behaviors (i.e., depression, anxiety, conduct problems, substance abuse)
- Improvements in help-seeking behavior
- Improvements in social competence and emotional regulation skills
- Improvements in problem-solving and conflict management skills

Evidence

Several social emotional learning and parenting and family relationship programs have been shown in rigorous evaluations to improve resilience and reduce risk factors for various behaviors, including ones closely related to suicide, such as depression, internalizing behaviors, and substance abuse (M. S. Knox, Burkhart, & Hunter, 2010).

- **Social emotional learning programs.** The *Youth Aware of Mental Health Program (YAM)* is a program developed for teenagers aged 14-16 that uses interactive dialogue and role-playing to teach adolescents about the risk and protective factors associated with suicide (including knowledge about depression and anxiety) and enhances their problem-solving skills for dealing with adverse life events, stress, school and other problems (Wasserman et al., 2014). In a cluster-randomized controlled trial conducted across 10 European Union countries and 168 schools, students in schools randomized to *YAM* were significantly less likely to attempt suicide and have severe suicidal ideation at the 12-month follow-up compared to students in control schools which received educational materials and care as usual. Overall, the relative risk of youth suicide attempts among the *YAM* group was reduced by over 50% demonstrating that out of 1000 students, five attempted suicide in the *YAM* group compared to 11 in the control group. Additionally, related to severe suicide ideation, in the *YAM* group absolute risk fell by 0.50% and relative risk fell by 49.6% (Wasserman et al., 2014).

  Another example is the *Good Behavior Game (GBG),* which is a classroom-based program for elementary school children aged 6-10. The program uses a team-based behavior management strategy that promotes good behavior by setting clear expectations for good behavior and consequences for maladaptive behavior. The goal of the *GBG* program is to create an integrated classroom social system that is supportive of all children being able to learn with little aggressive or disruptive behavior (Wilcox et al., 2008). Two cohorts of youths participated in the program in 1985-86 and 1986-87 school years when they were in the first and second grades. A number of proximal and distal outcomes were assessed among the two cohorts over time. With respect to distal suicide-related outcomes, an outcome evaluation of the *GBG* indicated that individuals in the first cohort who were assigned to participate in

Comment [A]: Should we add references for some of the systematic reviews on school and parenting/family programs?

Comment [A]: Dropped Signs of Suicide

Consider adding PATHS? Two examples may be fine here, so not sure we need to add another program.

GBG when they were in the first grade reported half the adjusted odds of suicidal ideation and suicide attempts when assessed approximately 15 years later, between the ages of 19 to 21, compared to peers who had been in a standard classroom setting. The beneficial effect of the program was consistent for suicidal ideation regardless of whether baseline covariates were included. The *GBG* effect on attempts was less robust in some adjusted models including caregiver mental health. In the second cohort of *GBG* students, neither suicidal ideation nor suicide attempts were significantly different between *GBG* and the control interventions (Wilcox et al., 2008). The researchers believed this may have been due to a lack of implementation fidelity. *GBG* was also found to be associated with reduced risk of later substance abuse, a risk factor for suicide (Kellam et al., 2008).

- **Parenting skill and family relationship programs.** Parenting and family skills training approaches have shown promising impacts in preventing key risk factors associated with suicide. For example, the *Incredible Years (IY)* is a comprehensive group training program for parents, teachers and children designed to reduce conduct and substance abuse problems, two important suicide risk factors in youth by improving protective factors such as responsive and positive parent-teacher-child interactions and relationships, emotion self-regulation and social competence (all protective factors for suicide) (Herman et al., 2011). The program includes 9-20 sessions offered in community-based settings (e.g., religious, recreation centers, mental health treatment centers, and hospitals). Several studies have demonstrated the effect of the *IY* program on reducing internalizing symptoms, such as anxiety and depression, and child conduct problems (C. H. Webster-Stratton, Reid, & Beauchaine, 2011; Webster-Stratton, Jamila Reid, & Stoolmiller, 2008). The program is also associated with improved problem-solving and conflict management; these skills were maintained at 1-year follow-up (Reid, Webster-Stratton, & Hammond, 2003; C. Webster-Stratton & Hammond, 1997; C. Webster-Stratton, Reid, & Hammond, 2001). The program demonstrated greater benefits as the dosage of the intervention increased (Herman et al., 2011).

  Additionally, *Strengthening Families 10-14* is a program that involves sessions between parents, youth, and family with the goal of improving parents' skills for disciplining, managing emotions and conflict, and communicating with their children; promoting youths' interpersonal and problem-solving skills; and creating family activities to build cohesion and positive parent-child interactions. The premise of the program is that developing these skills for both parents and children will reduce internalizing behavior and adolescent substance abuse, two important risk factors for suicide (Spoth, Guyll, & Day, 2002). *Strengthening Families* has been shown to significantly decrease externalizing behaviors, such as aggression, alcohol use, and drug use among youth participants, as well as reduce depression, alcohol use, and drug use among participating families (Spoth et al., 2002).

Identify and Support People At-Risk

Rationale

In order to decrease suicide, attention to people at increased risk is necessary, as these individuals tend to experience suicidal behavior at higher than average rates. These vulnerable or disadvantaged populations include, but are not limited to, individuals with lower socio-economic status or who are living with a mental health problem; people who have attempted suicide previously; Veterans and active duty military personnel; individuals who are institutionalized, have been victims of violence, or are homeless; and members of certain racial and ethnic minority groups. Supporting these vulnerable groups requires proactive case finding along with access to, and retention in, mental health services. Finding effective ways of identifying at-risk or vulnerable groups, customizing services to make them accessible and engaged in care remain key challenges. For example, simply improving services does not guarantee that those services will be used by those most in need of them, nor will it necessarily increase the number of people who follow treatments that are recommended. People who are disadvantaged face social and economic issues that may adversely affect their ability to access care and treatment.

Comment [A]: Add LGBTQ populations?

Approaches

The following three approaches focus on identifying and supporting people at increased risk.

- **Gatekeeper training** is designed to train teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating treatment seeking and support services. Gatekeeper training may be implemented in a variety of settings to identify and support people at risk.

- **Screening combined with care management and overall continuity of care** has been used in primary care and behavioral health care settings to assure that people who may be at high-risk of suicide are identified and receive ongoing treatment as needed, particularly after inpatient discharge and other transitions within the healthcare system so they don't 'slip through the cracks'. These approaches typically employ screening for depression and/or suicide combined with collaborative treatment planning between patients and their providers and patient follow-up.

- **Crisis intervention**. These approaches provide support and referral services, typically by connecting a person in crisis (or a friend or family member of someone at-risk) to trained volunteers or professional staff via telephone hotline, online chat, text messaging, or in-person. Crisis intervention approaches are intended to impact key risk factors for suicide, including

feelings of depression, hopelessness, and subsequent mental health care utilization. Like means reduction, crisis interventions can put space or time between an individual who may be considering suicide and harmful behavior.

Comment [A]: Moved ASIST here per reviewers comments.

Dropped MHFA – consider incorporating that program in another category?

Potential Outcomes

- Reductions in suicide attempts
- Reductions in suicide deaths
- Increases in identification of individuals at-risk for suicidal behavior
- Increases in at-risk individuals in treatment
- Increases in community members trained to identify at-risk individuals
- Increases in referrals for health care

Evidence

The current evidence suggests that identifying people at risk of suicide and the continued provision of support for these individuals can positively impact suicide and its associated risk factors.

- **Gatekeeper training**. *Applied Suicide Intervention Skills Training (ASIST)* is a widely implemented training program that helps hotline counselors, emergency workers, and other gatekeepers to identify and connect with suicidal individuals, understand their reasoning for living and dying, and assist with safely connecting those in need to available resources. In a study employing a randomized controlled trial, Gould, Cross, Pisani, Munfakh, & Kleinman (2013) evaluated the training across the *National Suicide Prevention Lifeline* network of hotlines over the period 2008-2009. Using data from 1,410 suicidal individuals who called 17 Lifeline centers, the researchers found that compared to callers who spoke to counselors that received the usual care training, individuals who spoke with counselors without training in *ASIST* were significantly more likely to feel depressed, suicidal, more overwhelmed, and less hopeful by the end of their call to the hotline compared to those with training in *ASIST*. Counselors trained in *ASIST* were also more skilled at keeping callers on the phone longer and establishing a connection with them. However, training in *ASIST* did not result in more comprehensive suicide risk assessments than usual care training (Gould et al., 2013).

  Gatekeeper training has also been a primary component of the *Garret Lee Smith (GLS) Suicide Prevention Program,* which is in place in 49 states and 48 tribes. A multi-site evaluation assessed the impact of community gatekeeper training on suicide attempts and deaths by comparing the change in suicide rates and nonfatal suicidal behavior among young people aged 10-24 in counties implementing *GLS* trainings, with the trajectory observed in similar counties that did not

implement these trainings. Counties that implemented *GLS* trainings had significantly lower youth suicide rates one year following the training implementation (Walrath, Garraza, Reid, Goldston, & McKeon, 2015). This finding equates to a decrease of 1 suicide death per 100,000 among youth ages 10 to 24, or the prevention of approximately 237 deaths in the age group, between 2007 and 2010. Counties implementing *GLS* program activities also had significantly lower suicide attempt rates among youth ages 16 to 23 in the year following implementation of the *GLS* program than did similar counties that did not implement *GLS* activities (4.9 fewer attempts per 1000 youths; Godoy Garraza, Walrath, Goldston, Reid, & McKeon, 2015). More than 79,000 suicide attempts may have been prevented during the period examined, following implementation of the *GLS* program.

- **Screening combined with care management and overall continuity of care.** The *Henry Ford* healthcare system is a large health maintenance organization (HMO) in the state of Michigan. *Henry Ford's Perfect Depression Care* program was the pre-cursor to what is now called *Zero Suicide*, and its overall goal was to eliminate suicide among its members. More broadly, the goal of the program was to redesign delivery of depression care to achieve "breakthrough improvement" in quality and safety by focusing on effectiveness, safety, patient centeredness, timeliness, efficiency, and equity among patients. The program screened and assessed each patient for suicide risk and implemented coordinated continuous follow-up care system wide (C. E. Coffey, 2006). An examination of the impact of the program found that there was a dramatic and statistically significant decrease in the rate of suicide between the baseline years, 1999 and 2000, prior to the intervention to the intervention years, 2002-2009. During this time period, the suicide rate fell by 82% (C. E. Coffey, 2006; C. E. Coffey, Coffey, & Ahmedani, 2013). Further, among HMO members who received mental health specialty services, the suicide rate significantly decreased over time from 1999 to 2010 (110.3 to 47.6 per 100,000; $p<.04$) with a mean of 36.2 per 100,000 over the period. Additionally, for those HMO members who accessed only general medical services as opposed to specialty mental health services, the suicide rate increased from 2.7 to 5.6 per 100,000 ($p<.01$). Similarly, in the state of Michigan, rates of suicide in the general population increased over the period from 9.8 to 12.5 per 100,000 ($p<.001$) (M. Coffey, Coffey, & Ahmedani, 2015).

- **Crisis intervention.** Suicide prevention hotlines are one way to provide crisis intervention. In an evaluation of the effectiveness of the *National Suicide Prevention Lifeline* to prevent suicide, 1,085 suicidal individuals who called the hotline completed a standard risk assessment for suicide, and 380 of those completed a follow-up assessment between 1 and 52 days (mean=13.5 days) after the initial assessment. Researchers found that over half of the initial sample were seriously considering suicide when they called, and they had a plan for their suicide. Researchers also found that among follow-up participants, there was a significant decrease in psychological

pain, hopelessness, and intent to die between initiation of the call (time 1) to follow-up (time 3). Between time 2 (end of the call) to time 3, the effect remained for psychological pain and hopelessness, but was not significant for intent to die (Gould, Kalafat, Harrismunfakh, & Kleinman, 2007).

DRAFT

Intervene to Lessen Harms and Prevent Future Risk

Rationale

Individuals who have experienced mental health challenges, suicidal ideation, who have made suicide attempts or engaged in non-suicidal self-injury are at increased risk of suicide (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Risk of suicide can also increase among those who have lost a friend, family member, co-worker, or other acquaintance to suicide (Pitman, Osborn, King, & Erlangsen, 2014). Exposure to sensationalized or uninformed reporting regarding on suicide may heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion (Etzersdorfer & Sonneck, 1998; Niederkrotenthaler & Sonneck, 2007).

Approaches

There are a number of approaches that can be used to lesson harms and reduce future risk of suicide including various therapeutic treatments and approaches providing continuity of care, caring for the bereaved, and safe reporting following a suicide.

- **Treatment for people at-risk of suicide** typically includes various forms of psychotherapy delivered by licensed providers to help individuals with mental health problems and other risk factors for suicide with problem-solving, impulsivity and emotion regulation. Treatment usually takes place in a one on one or group format between patients and clinicians in mental healthcare settings, but may also involve primary care providers. Treatment can vary in duration from several weeks to ongoing therapy for years in some cases.

- **Treatment to prevent re-attempts.** These approaches typically include follow-up contact and use diverse modalities (e.g., home visits, mail, telephone, e-mail) to engage recent suicide attempt survivors in continued treatment to prevent re-attempts. Treatment may focus on improved coping skills, mindfulness, and other emotional regulation skills, and may include case management home visits to increase adherence to treatment and continuity of care; and one-on-one interpersonal therapy and/or group therapy. Approaches that engage and connect attempters to peers and providers are especially important because many attempters do not present to aftercare; 12%-25% reattempt within a year, and 3%-9% of attempt survivors die by suicide within 1 to 5 years of their initial attempt (Inagaki et al., 2015)

- **Postvention** approaches are implemented *after* a suicide has taken place and may include debriefing sessions, counseling, and/or bereavement support groups for surviving friends and family members/loved ones. These programs have not typically been evaluated for their impact on suicide or suicidal behavior but may reduce survivors' guilt, feelings of depression, and complicated grief (Szumilas & Kutcher, 2011).

Comment [A]: Wonder if it would just be better to end the sentence after the word "clinicians"?

- **Safe reporting following a suicide.** The manner in which information on a recent suicide is communicated to the public (e.g. school assemblies, mass media, social media) can heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion. Therefore, responsible and safe reporting may help prevent suicide and suicide contagion.

Potential Outcomes

- Reductions in mental health-related sequelae
- Increases in connectedness
- Improvements in coping skills
- Improvements in messaging following suicide
- Reductions in re-attempts
- Reductions in contagion effects related to suicide

Evidence

Current evidence suggests that therapeutic treatments and other approaches for lessening harm can impact risk and protective factors for suicide.

- **Treatment for people at-risk of suicide**. One example of a treatment with evidence of impact on risk and protective factors for suicide is the *Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)* program. *IMPACT* aims to prevent suicide among older primary care patients by reducing suicide ideation and depression in primary care settings. It facilitates the development of a therapeutic alliance, a personalized treatment plan that includes patient preferences, as well as proactive follow-up (biweekly during an acute phase and monthly during continuation phase) by a depression care manager (Hunkeler et al., 2006). The program has been shown to significantly improve quality of life, and to reduce functional impairment, depression and suicidal ideation over 24-months of follow-up (Hunkeler et al., 2006; Unutzer et al., 2006) relative to patients who received care as usual.

  Another example is *Collaborative Assessment and Management of Suicidality (CAMS)*, which is a therapeutic approach for suicide-specific assessment and treatment of patient's suicide risk. This flexible approach can be used across treatment settings and clinician theoretical orientations and involves the clinician and patient working together in an interactive assessment process to develop patient-specific treatment plans. *CAMS* sessions are collaborative and involve constant patient input about what is and is not working with the ultimate goal of enhancing the

therapeutic alliance and increasing treatment motivation in the suicidal patient. *CAMS* been tested and supported in 6 correlational studies (Jobes, 2012), in a variety of inpatient and outpatient settings and in one RCT with several additional RCTs under way. *CAMS* has been associated with significant improvements in suicidal ideation, overall symptom distress, and feelings of hopelessness at 12 month follow-up among a community-based sample of suicidal outpatients. (Comtois et al., 2011).

Other examples include *Dialectical Behavioral Therapy (DBT)* and *Attachment-Based Family Therapy (ABFT). DBT* is a multicomponent therapy for individuals at high risk for suicide and who may struggle with impulsivity and emotional regulation. The components of *DBT* include individual therapy, group skills training, between-session telephone coaching and a therapist consultation team. In a randomized controlled trial of women with recent suicidal or self-injurious behavior, those receiving *DBT* were half as likely to make a suicide attempt at two-year follow-up than women receiving community treatment (23% vs 46%), required less hospitalization for suicide ideation, and had lower medical risk across all suicide attempts and self-injurious acts combined (Linehan et al., 2006).

ABFT is a program for adolescents aged 12-18 and is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety (Diamond et al., 2010). A randomized controlled trial of ABFT found that suicidal adolescents assigned to *ABFT* experienced significantly greater improvement in suicidal ideation over 24 weeks of follow-up than did adolescents assigned to enhanced usual care. Additionally, a significantly higher percentage of *ABFT* participants reported no suicidal ideation in the week prior to assessment at 12 weeks than did adolescents receiving enhanced usual care (69.2% vs. 34.6%) and at 24 weeks (82.1% vs. 46.2%) (Diamond et al., 2010).

- **Treatment to prevent re-attempts.** Several strategies that aim to prevent re-attempts have demonstrated impact on reducing suicidal behavior. For example, *Emergency Department Brief Intervention with Follow-up Visits* is a program that involves a one-hour discharge information session that addresses suicidal behavior, distress, risk and protective factors, alternatives to suicidal behavior, and referral options, combined with nine follow-up contacts over 18 months (at 1, 2, 4, 7, 11 weeks and 4, 6, 12, 18 months). Follow-up contacts are either conducted by phone or through home visits according to a specific time line for up to 18-months. A randomized controlled trial that enrolled suicide attempters from eight hospital emergency departments in five countries (Brazil, India, Sri Lanka, Iran, and China) found that a brief intervention combined with 9 follow-up visits over 18-months was associated with significantly fewer deaths from suicide relative to a treatment-as-usual group (0.2% versus 2.2%, respectively) (Fleischmann et al., 2008).

Another example of treatment to prevent re-attempts involves *active follow-up contact approaches* such as postcards, letters, and telephone calls intended to increase a patient's sense of connectedness with health care providers and decrease isolation. These approaches include expression of care and support and typically invite patients to reconnect with their provider. Contacts are made periodically (e.g., monthly or every few months in the first 12 months post-discharge with some programs continuing contact for two or more years). In a meta-analysis conducted by Inagaki et al. (2015), interventions to prevent repeat suicidal behavior in patients admitted to an emergency department for suicide attempt were found to reduce reattempts by approximately 17% for up to 12 months post-discharge; however, the effects of these approaches beyond 12 months on reattempts has not yet been demonstrated. Also, because the number of trials and associated sample sizes included in this meta-analysis were small, it was not possible to determine the effect of active contact and follow-up approaches on death by suicide.

In a randomized controlled trial of the post-crisis suicide prevention long-term follow-up contact approach, Motto and Bostrom (2001) found that patients who refused ongoing care but who were randomized to be contacted by letter four times per year had a lower rate of suicide over two years of follow-up than did patients in the control group who received no further contact. Other studies have also shown post-crisis letters and coping cards to be protective against suicide ideation and attempts (Hassanian-Moghaddam, Sarjami, Kolahi, & Carter, 2011; Wang et al., 2016).

Finally, *Cognitive Behavior Therapy for Suicide Prevention (CBT-SP*) is an example of a therapeutic approach to prevent re-attempts. It uses a risk-reduction, relapse prevention approach that includes an analysis of proximal risk factors and stressors (e.g., relationship problems, school or work-related difficulties) leading up to and following the suicidal event; safety plan development; skill building; and psychoeducation. *CBT-SP* also has family skill modules focused on family support and communication patterns as well as improving the family's problem solving skills. A randomized controlled trial of *CBT-SP* found that 10-session outpatient cognitive therapy designed to prevent repeat suicide attempts resulted in a 50% reduction in the likelihood of a suicide reattempt among adults who had been admitted to an emergency department for a suicide attempt relative to treatment as usual (Brown et al., 2005).

- **Postvention** programs are implemented with the goal of providing support to survivors of others' suicide to reduce their own risk of suicide. One example of a postvention program, *StandBy Response Service* (*StandBy),* provides clients with face-to-face outreach and telephone support through a professional crisis response team. Site coordinators develop customized case management plans, referring clients to other existing community services matched to their needs

(Visser, Comans, & Scuffham, 2014). In a study by Visser et al. (2014), *StandBy* clients were significantly less likely to be at high risk for suicidality than a suicide bereaved comparison group who had not had contact with the *StandBy* program (48% and 64% respectively). Additionally, research suggests that active postvention approaches in which outreach to suicide survivors occurs at the scene of a suicide is associated with intake into treatment sooner, greater attendance at support group meetings, and attendance at more meetings compared to passive postvention (versus passive approaches where survivors self-refer for services) (J. Cerel & Campbell, 2008).

- **Safe reporting following a suicide.** One way to ensure safe reporting following a suicide is to encourage news media adhere to *Recommendations for Reporting on Suicide* (http://www.reportingonsuicide.org). Reports that are both inclusive of suicide prevention messages, stories of hope and resilience, risk and protective factors, and links to helping resources (e.g., hotline), and that avoid sensationalizing events or reducing suicide to one cause, can help reduce the likelihood of suicide contagion. The most compelling evidence supporting these recommendations for reporting comes from Austria. After a sharp increase in suicides on the Viennese subway, media guidelines were introduced and an interrupted time series design was used to evaluate the national impact of the guidelines on subsequent suicides. Changes in the quality and quantity of media reporting resulted in a nationwide significant reduction of 81 suicides annually (Niederkrotenthaler & Sonneck, 2007). Finally, research suggests that not only does reporting on suicide in a negative way (e.g., reporting on suicide myths and repetition) have harmful effects on suicide, but reporting on positive coping skills in the face of adversity can also demonstrate protective effects against suicide (Niederkrotenthaler et al., 2010). Reports of individual suicidal ideation not accompanied by reports of suicide or suicide attempts, along with reports describing a "mastery" of a crisis situation where adversities were overcome, was associated with significant decreases in suicide rates in the time period immediately following such reports (Niederkrotenthaler et al., 2010).

Sector Involvement

Public health can play an important and unique role in addressing suicide. Public health agencies, which typically place prevention at the forefront of efforts and work to create broad population-level impact, can bring critical leadership and resources to bear on this problem. For example, these agencies can serve as a convener, bringing together partners and stakeholders to plan, prioritize, and coordinate suicide prevention efforts. Public health agencies are also well positioned to collect and disseminate data, implement preventive measures, evaluate programs, and track progress. Although public health can play a leadership role in preventing suicide, the strategies and approaches outlined in this technical package cannot be accomplished by the public health sector alone. As noted in the National Strategy to Prevent Suicide, the integration and coordination of prevention activities across sectors and settings is critical for expanding the reach and impact of suicide prevention efforts.

Other sectors vital to implementing this package include, but are not limited to, education, government (local, state, and federal), social services, health services, business, labor, justice, housing, media, and organizations that comprise the civil society sector such as faith-based organizations, youth-serving organizations, foundations, and other non-governmental organizations. Collectively, these sectors can make a difference in preventing suicide by impacting the various contexts and underlying risks that contribute to suicide.

The strategies and approaches described in this technical package are summarized in Appendix A along with the relevant sectors that are well positioned to lead implementation efforts. For example, business and labor, health care insurers and providers, and government entities are in the best position to implement programs and policies that *Strengthen Economic Supports* and *Access to Mental Health Care*. These types of supports go beyond individual behavior change and require commitment and support from those sectors that can directly address some of the underlying risks and the environmental contexts that increase the risk for suicide. Public health entities can play an important role by gathering and synthesizing information to inform policy, raise awareness, and evaluate the effectiveness of various policies. Moreover, partnerships with non-governmental and community organizations can be instrumental in increasing awareness of and garnering support for policies affecting individuals and families.

The public health sector has been at the forefront of many community-based prevention efforts, working collaboratively with schools and community-based organizations, to change social norms and positively impact health behavior. Public health is well suited to take on a similar leadership role in *Promoting Connectedness* through peer norm and community engagement activities and supporting the development, evaluation, and adoption of effective programs that *Teach Coping and Problem-Solving Skills* to prevent suicide from happening in the first place. These programs are often delivered in school

and community settings, making education and non-governmental organizations vital partners in prevention.

Businesses, workplaces, and local and state government entities, on the other hand, are in the best position to establish policies and support practices that *Create Protective Environments* where people live, work, and play. Public health entities can play an important role by gathering and synthesizing information, working with other agencies within the executive branch of their state or local government in support of policy and other approaches, and evaluating the effectiveness of measures taken. In a similar fashion, public health entities can partner with schools, workplaces, and community organizations to implement and evaluate prevention programs, policies and practices geared toward creating safe, healthy, and supportive environments.

Finally, this technical package includes a number of interventions delivered in hospital, primary care, behavioral health care, and community settings designed to *Identify and Support People At-Risk* and to *Lessen Harms and Prevent Future Risk*. The intensity and activities of these interventions require the expertise of professionals who are licensed and trained to deliver critical intervention support. The health care, social services, and justice sectors can work collaboratively to support individuals at high-risk for suicide and their families. These activities also require coordination of supports across various service providers and community organizations.

Regardless of strategy, action by many sectors will be necessary for the successful implementation of this package. In this regard, all sectors can play an important and influential role in preventing suicide from happening in the first place and lessening the immediate and long-term harms of suicidal behavior by helping those in times of crisis get the services and support they need.

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Monitoring and Evaluation

Monitoring and evaluation are necessary components of the public health approach to prevention. It is important to have timely and reliable data to monitor the extent of the problem and to evaluate the impact of prevention efforts. Data are also necessary for prevention planning and implementation.

Gathering ongoing and systematic data is important for prevention efforts. However, it is also important to gather data that are uniform and consistent across systems. Consistent data allow public health and other entities to better gauge the scope of the problem, identify high-risk groups, and monitor the effects of prevention programs and policies. Currently, it is common for....add more CDC's uniform definitions and recommended data elements for self-directed violence provide a useful framework to help ensure that data are collected in a consistent manner across surveillance systems and data collection sites (e.g., A.E. Crosby, Ortega, et al., 2011).

Surveillance data help researchers and practitioners track changes in the burden of suicide. Surveillance systems exist at the federal, state, and local levels. It is important to assess the availability of surveillance data and data systems across these levels to identify and address gaps in the systems. CDC's National Vital Statistics System (NVSS) and the National Violent Death Reporting System (NVDRS) are examples of surveillance systems that provide data on deaths from suicide. NVSS is a nationwide surveillance system that collects demographic, geographic, and cause-of-death data from death certificates. NVDRS is a state-based surveillance system (currently in 40 states, DC and Puerto Rico) that combines data from death certificates, law enforcement reports, and coroner or medical examiner reports to provide detailed information on the circumstances of violent deaths, including suicide, which can assist communities in guiding prevention approaches (Blair, Fowler, Jack, & Crosby, 2016). The National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP) provides nationally representative data about all types and causes of nonfatal injuries treated in U.S. hospital emergency departments, and can be used to assess national rates of, and trends in, self-harm injuries by cause (e.g., falls, poisoning, etc.), age, race/ethnicity, sex, disposition (where the injured person goes when released from the Emergency Department).

In addition to information on deaths and nonfatal injuries, there are also surveillance systems that provide national, state, and some local estimates of suicidal behavior. The Youth Risk Behavior Surveillance System (YRBSS) collects information from a nationally representative sample of 9-12 grade students and is a key resource in monitoring health-risk behaviors among youth, including whether youth have seriously considered attempting suicide, attempted suicide, made a plan, or required treatment by a doctor or nurse for a suicide attempt that resulted in an injury, poisoning, or overdose (Brener et al., 2013). The YRBSS data are obtained from a national school-based survey conducted by CDC as well as from state, territorial, tribal, and large urban school district surveys conducted by education and health agencies. The National Survey on Drug Use and Health (NSDUH) is an annual survey of the civilian, non-institutionalized population aged 12 years and older. NSDUH provides both national and state-level

estimates of substance use (alcohol, tobacco, illicit drugs, and non-medical use of prescription drugs); mental health (past year mental illness, co-occurring illnesses); and service utilization, along with suicide ideation, suicide plans, and suicide attempts. NSDUH is a key resource to track trends in suicide-related risk factors in the population and to help identify groups at increased risk.

It is also important at all levels (local, state, and federal) to address gaps in responses, track progress of prevention efforts and evaluate the impact of those efforts, including the impact of this technical package. Evaluation data, produced through program implementation and monitoring, is essential to provide information on what does and does not work to reduce rates of suicide and its associated risk and protective factors. Theories of change and logic models that identify short, intermediate, and long-term outcomes are an important part of program evaluation.

The evidence-base for suicide prevention has advanced greatly over the last few decades. However, additional research is needed to understand the impact of programs, policies, and practices on suicide (and suicide attempts, at a minimum), as opposed to merely examining their effectiveness on risk factors. More research is also needed to examine the effectiveness of primary prevention strategies (before risk occurs) and community-level strategies to prevent suicide at the population level. Lastly, it will be important for researchers to test the effectiveness of combinations of the strategies and approaches included in this package. Most existing evaluations focus on approaches implemented in isolation, but there is potential to understand the synergistic effects within a comprehensive prevention approach.

Conclusion

Suicide is a serious public health problem whose rates have been on the rise for more than a decade and whose costs stretch well into the billions of dollars each year. While suicide is a rare outcome statistically, its human impact has a ripple effect that is far-reaching. Each of us likely interacts with suicide survivors, those with lived experience, and those with thoughts of suicide on a daily basis – at home, at work, and in our communities. Suicide and suicide attempts are public health issues of societal concern. There are a number of barriers that have impeded progress, including, for example, stigma related to help-seeking, mental illness, being a survivor and fear related to asking someone about suicidal thoughts. Fortunately, like many public health problems, suicide is preventable, and more is being done to prevent suicide than ever before, as evidenced by the work of the National Action Alliance for Suicide Prevention, the release of the first world report on suicide, and more timely surveillance data, to name just a few examples.

In an effort to continue pushing the field and society further towards prevention, this technical package includes strategies and approaches that ideally would be used in a comprehensive, multi-level and multi-sectoral way. It includes strategies and approaches to prevent suicide from occurring in the first place, as well as strategies focused on lessening the immediate and long-term harms of suicidal behavior. It includes strategies that range from a focus on the whole population regardless of risk to strategies

designed to support people at highest risk. Importantly, this technical package extends the bounds of the typical prevention strategies to consider approaches that go beyond individual behavior change to better address risk factors impacting communities and populations more broadly (e.g., economic policies to strengthen housing and financial security).

While the evidence base continues to emerge, the collection of programs, policies, and practices laid out here are available for implementation now. In keeping with good public health practice, the intent is that monitoring and evaluation will play a key role in that implementation. Moreover, as new evidence becomes available, this technical package can be refined to reflect the current state of the science.

In closing, and in keeping with a message of resilience as spoken by those with lived experience, 'hope, help, and healing is possible.'

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Appendix A: Summary of Strategies and Approaches to Prevent Suicide

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		Suicide	Suicide Attempts or Ideation	Other Risk/Protective Factors for Suicide	
Strengthen economic supports	**Strengthen household financial security**				Government (local, state, Federal) Business/labor
	Unemployment benefit programs	✓			
	Other income supports	✓			
	Housing stabilization policies				Government (local, state, Federal)
	The National Neighborhood Stabilization Program			✓	
Strengthen access to mental health care	**Coverage of mental health conditions in health insurance policies**				Health care Government (state, Federal)
	Mental Health Parity Laws	✓		✓	
Create protective environments	**Reducing access to lethal means among persons at-risk**				Government (local, state) Public Health
	Intervening at suicide hot spots	✓			
	Safe storage practices		✓	✓	
	Organizational policies and culture				Business/Labor Government (local, state, Federal)
	Together for Life	✓			
	US Air Force Suicide Prevention Program	✓		✓	

		Best Available Evidence			
	Community-based policies to reduce excessive alcohol use				Government (local, state)
	Alcohol outlet density	✓		✓	Business/labor
Promote connectedness	**Peer norm approaches**				Public Health
	Sources of Strength			✓	Education
	Community-engagement activities				Public Health
	Greening vacant urban spaces			✓	Government (local)
Teach coping and problem-solving skills	**Social emotional learning**				Public Health
	Youth Aware of Mental Health Program		✓		Education
	Signs of Suicide		✓	✓	
	Good Behavior Game		✓	✓	
	Parenting skill and family relationship approaches				Public Health
	The Incredible Years			✓	Education
	Strengthening Families 10-14			✓	
	Gatekeeper training				Public Health
	Applied Suicide Intervention Skills Training		?	✓	Healthcare

		Best Available Evidence			
Identify and support people at-risk	**Screening combined with care management**				Healthcare Social Services
	Henry Ford Perfect Depression Care (Pre-cursor to Zero Suicide)	✓		✓	
	Crisis Intervention				Public Health Social Services
	National Suicide Prevention Lifeline		✓	✓	
Intervene to lessen harms and prevent future risk	**Treatment for people at risk of suicide**				Healthcare Social Services Justice
	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)		✓	✓	
	Collaborative Assessment and Management of Suicidality (CAMS)		✓	✓	
	Dialectical Behavioral Therapy		✓	✓	
	Attachment-Based Family Therapy		✓		
	Treatment to prevent re-attempts				Healthcare Social Services
	ED Brief Intervention with Follow-up Visits	✓			
	Active follow-up contact approaches	✓	✓		
	CBT for Suicide Prevention				
	Postvention				Healthcare
	StandBy Response Service		✓		

		Best Available Evidence			
	Safe reporting following a suicide				Public Health
	Media Guidelines	✓			Media

[1]This column refers to the lead sectors well positioned to bring leadership and resources to implementation efforts. For each strategy, there are many other sectors such as non-governmental organizations that are instrumental to prevention planning and implementing specific activities.

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Preventing Suicide:
A Technical Package of Policy, Programs, and Practices

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2017

Comment [A]: Additional comments from Jim:

This looks great. I just have a few suggestions/comments which I'll summarize here:

1. Page 7 or somewhere: Although it is mentioned that violent victimization is a risk factor for suicide on page 7 I think that somewhere in this area we ought to punch up that fact. That is the prevention of interpersonal violence is a strategy for suicide prevention because I think it will be useful when we come back to look at cross-cutting strategies. So I'd suggest in just a sentence or two that we somehow put a little emphasis on that particular risk factor.

2. Economic toll of suicide: Across the board we have to be very careful of the way we use the economic estimates. There methods vary to such a great extent its tricky to compare them. On page 9 the CDC/Florence estimates are compared with the Shepard study. The suggestion is that the difference is due to the Shepard study adjusting for suicide underreporting. However, I believe that there are many other differences in the costs included in these two methods as well. I would amend to briefly mention how the Shepard estimates also includes other domains of cost as compared to the CDC/Florence estimate.

3. Page 17: The second bit of evidence in support of the health insurance policies isn't really supportive as it is just limited to how much it costs per suicide prevented. If that could be compared to the cost of a suicide to society then you have a cost/benefit results. As is it's not really evidence of effectiveness. We may want to consider dropping if we can't reword or re-contextualize this.

4. Page 40: While the word upstream is pretty well recognized within public health circles it might not be understood as well outside of those. Why

***Preventing Suicide: A Technical Package of Policies, Programs, and Practices* is a publication of the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention.**

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[to be inserted later]

External Reviewers

[to be inserted later]

Overview

This technical package represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide. These strategies include strengthening economic supports; strengthening access to mental health care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at-risk; and intervening to lessen harms and prevent future risk. The strategies represented in this package include those with a focus on preventing suicide from happening in the first place as well as approaches to lessen the immediate and long-term harms of suicidal behavior for individuals, families, communities, and society. The strategies in the technical package support the goals and objectives of the National Strategy for Suicide Prevention and the National Action Alliance for Suicide Prevention's priority to strengthen community-based prevention. Commitment, cooperation, and leadership from numerous sectors, including public health, education, justice, health care, social services, business, labor, and government can bring about the successful implementation of this package.

What is a Technical Package?

A technical package is a compilation of a core set of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome (Frieden, 2014). Technical packages help communities and states prioritize prevention activities based on the best available evidence. This technical package has three components. The first component is the ***strategy*** or the preventive direction or actions to achieve the goal of preventing suicide. The second component is the ***approach***. The approach includes the specific ways to advance the strategy. This can be accomplished through *programs, policies, and practices*. The approaches included come primarily from studies based in the United States. The ***evidence*** for each of the approaches in preventing suicide or its associated risk factors is included as the third component. This package is intended as a resource to guide and inform prevention decision-making in communities and states.

Preventing Suicide is a Priority

Suicide, as defined by the Centers for Disease Control and Prevention (CDC), is part of a broader class of behavior called *self-directed violence*. Self-directed violence refers to behavior directed at oneself that deliberately results in injury or the *potential* for injury (A.E. Crosby, Ortega, & Melanson, 2011). Self-directed violence may be *suicidal* or *non-suicidal* in nature. For the purposes of this document, we refer only to behavior where suicide is intended:

- **Suicide** is a death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

- **Suicide attempt** is defined as a *non-fatal* self-directed and potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicide is highly prevalent. Suicide presents a major challenge to public health in the United States and worldwide. It contributes to premature death, morbidity, lost productivity, and health care costs (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014). In 2014 (the most recent year of available death data), suicide was responsible for 42,773 deaths in the U.S., which is approximately one suicide every 12 minutes (Centers for Disease Control and Prevention, 2016c). In 2014, suicide ranked as the 10th leading cause of death and has been among the top 12 leading causes of death since 1975 in the U.S (Centers for Disease Control and Prevention, 2016c). Overall suicide rates have increased 24% from 1999 to 2014 (Curtin, Warner, & Hedegaard, 2016). Suicide is a problem throughout the life span; it is the second leading cause of death among those aged 10–34 years; it is the fourth leading cause among persons in their 40s and seventh among persons in their 50s. Suicide rates vary by race/ethnicity with the highest rates, across the lifespan, occurring among non-Hispanic American Indian/Alaska Native (AI/AN) (rate: 17.8/100,000). Among AI/AN, young people are disproportionately at increased risk of suicide with young males aged 25-29 experiencing the highest rates (rate: 56.9/100,000). Moreover, suicide rates among non-Hispanic AI/AN have increased by 48.7% since 1999 (Centers for Disease Control and Prevention, 2016c).

Suicides reflect only a portion of the problem (A.E. Crosby, Han, Ortega, Parks, & Gfroerer, 2011). Substantially more people are hospitalized as a result of nonfatal suicidal behavior (i.e. suicide attempts) than are fatally injured, and an even greater number are either treated in ambulatory settings (e.g., emergency departments) or not treated at all (A.E. Crosby, Han, et al., 2011). For example, during 2014, among adults aged 18 years and older, for every one suicide there were 9 adults treated in hospital emergency departments for self-harm injuries, 27 who reported making a suicide attempt, and over 227 who reported seriously considering suicide (i.e. ideation) (Ferdon et al., In press).

Suicide is associated with several risk and protective factors. Suicide, like other human behaviors, has no single determining cause. Instead, suicide occurs in response to multiple biological, psychological, interpersonal, environmental and societal influences that interact with one another, often over time. The social-ecological model-- encompassing multiple levels of focus from the individual, relationship, community, and societal-- is a useful framework for viewing and understanding suicide risk factors identified in the literature (Dahlberg & Krug, 2002). Risk and protective factors for suicide exist at each level. For example, risk factors include:

- **Individual level**: History of depression and other mental illnesses, hopelessness, substance abuse, certain health conditions, previous suicide attempt, violence victimization and perpetration, and genetic and biological determinants
- **Relationship level**: High conflict or violent relationships, sense of isolation and lack of social support, family/loved one's history of suicide, financial and work stress

- **Community level**: Inadequate community connectedness, barriers to health care (e.g., lack of access to providers and medications)
- **Societal level**: Availability of lethal means of suicide, unsafe media portrayals of suicide, stigma associated with help-seeking and mental illness (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014).

It is important to recognize that the vast majority of individuals who are depressed or who have other risk factors noted, do *not* die by suicide. Furthermore, the relevance of each risk factor can vary by age, race, gender, sexual orientation, residential geography, and socio-cultural and economic status (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014).

Protective factors, or those influences that guard *against* the risk for suicide, can also be found across the different levels of the social-ecological model. Protective factors identified in the literature include: effective coping and problem solving skills, moral objections to suicide, strong and supportive relationships with partners, friends, and family; connectedness to school, community and other social institutions; availability of quality and ongoing physical and mental health care, and reduced access to lethal means (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014). These protective factors can either counter a specific risk factor or guard against a number of risks associated with suicide.

Suicide is connected to other forms of violence. Suicide and other forms of violence often share some of the same root causes (Butchart, Phinney, Check, & Villaveces, 2004; Klevens, Simon, & Chen, 2012). For example, in neighborhoods where there is low social cohesion, or where residents don't support and trust each other, people are at higher risk for suicide (Desai, Dausey, & Rosenheck, 2005) as well as perpetration of child maltreatment (Coulton, Crampton, Irwin, Spilsbury, & Korbin, 2007; Freisthler, Merritt, & LaScala, 2006), teen dating violence (Capaldi, Knoble, Shortt, & Kim, 2012), intimate partner violence (Pinchevsky & Wright, 2012), and youth violence (Sampson, Morenoff, & Gannon-Rowley, 2002). Additionally, a lack of economic opportunities and unemployment are associated with suicide (Luo, Florence, Quispe-Agnoli, Ouyang, & Crosby, 2011; Reeves et al., 2012), as well as perpetration of child maltreatment (D. Runyan, Wattam, Ikeda, Hassan, & Ramiro, 2002), intimate partner violence (Heise & Garcia-Moreno, 2002; Pinchevsky & Wright, 2012), sexual violence (Centers for Disease Control and Prevention, 2016b) and youth violence (Wilson, 2011). Other shared risk factors for suicide and violence occur at the individual level and include substance abuse, mental health problems, witnessing violence, and a lack of problem-solving skills (Centers for Disease Control and Prevention, 2016a, 2016b, 2016d; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012).

Just as risk factors may be shared across suicide and violence, so too may protective factors overlap. For example, connectedness to one's community (Kleiman, Riskind, Schaefer, & Weingarden, 2012), school

Comment [A]: Took out many of the citations to facilitate reading as suggested.

(Carter, McGee, Taylor, & Williams, 2007), family (Maimon, Browning, & Brooks-Gunn, 2010), caring adults (Capaldi et al., 2012; Losel & Farrington, 2012), and pro-social peers (Wyman et al., 2010) enhances resilience to suicide and other forms of violence.

The health and economic consequences of suicide are substantial. Suicide and suicide attempts have far reaching consequences for individuals, families, and communities (Dunne, McIntosh, & Dunne-Maxim, 1987; Mishara, 1995; National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force, 2014; National Action Alliance for Suicide Prevention: Survivors of Suicide Loss Task Force, 2015). In an early study, Crosby and Sacks (2002) estimated that 7% of the U.S. adult population, or 13.2 million adults, knew someone in the prior 12 months who had died by suicide. They also estimated that for each suicide, 425 adults were exposed, or knew about the death. In a more recent study, in one state, Cerel et. al (2016) found that 48% of the population knew at least one person who died by suicide in their lifetimes. Research indicates that the impact of knowing someone who died by suicide and/or having lived experience (i.e. having attempted suicide oneself) is much more extensive than injury and death. People with lived experience may suffer long-term health and mental health consequences ranging from anger, guilt, and physical impairment, depending on the means and severity of the attempt (Chapman & Dixon-Gordon, 2007). Similarly, survivors of a loved one's suicide may experience ongoing pain and suffering including complicated grief (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004), stigma, depression, anxiety, post-traumatic stress disorder, and increased risk of suicidal ideation and suicide (Julie Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014; Sudak, Maxim, & Carpenter, 2008). Less discussed but no less important, are the financial and occupational effects for those left behind (Florence, Simon, Haegerich, Luo, & Zhou, 2015).

The economic toll of suicide is immense as well. According to conservative estimates, in 2013, suicide cost $50.8 billion in estimated lifetime medical and work-loss costs (Florence et al., 2015). By another estimate, the total lifetime costs associated with nonfatal injuries and deaths caused by self-directed violence in 2013 were approximately $93.5 billion after adjusting for under-reporting of suicide (Shepard, Gurewich, Lwin, Reed, & Silverman, 2016). The overwhelming burden of these costs results from lost productivity over the life course, with the average cost per suicide being over $1.3 million (Shepard et al., 2016).

Suicide can be prevented. Despite the myths surrounding suicide, like most public health problems, suicide is preventable (U.S. Public Health Service, 1999). And while progress will continue to be made into the future, evidence for numerous programs, practices, and policies currently exists, and many programs are ready to be implemented now. Just as suicide is not caused by a single factor, research suggests that suicide will not be prevented by any single intervention taking place in any single setting (Silverman & Maris, 1995; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Rather, suicide prevention is best achieved by a focus across the individual, relationship, family, community, and societal-levels and across all sectors, private and public (e.g.,

business, public health, physical and behavioral healthcare, justice, education, labor) (National Action Alliance for Suicide Prevention, 2014; World Health Organization, 2014).

Assessing the Evidence

This technical package includes programs, practices, and policies with evidence of impact on suicide or risk or protective factors for suicide. To be considered for inclusion in the technical package, the program, practice, or policy selected had to meet at least one of these criteria: a) meta-analyses or systematic reviews showing impact on suicide; b) evidence from at least one rigorous (e.g., randomized controlled trial [RCT] or quasi-experimental design) evaluation study that found significant preventive effects on suicide; c) meta-analyses or systematic reviews showing impact on risk or protective factors for suicide, or d) evidence from at least one rigorous (e.g., RCT or quasi-experimental design) evaluation study that found significant impacts on risk or protective factors for suicide. Finally, consideration was also given to the likelihood of achieving beneficial effects on multiple forms of violence; no evidence of harmful effects on specific outcomes or with particular subgroups; and feasibility of implementation in a U.S. context if the program, policy, or practice has been evaluated in another country.

Within this technical package, some approaches do not yet have research evidence demonstrating impact on rates of suicide but instead are supported by evidence indicating impacts on risk or protective factors for suicide (e.g., help-seeking, stigma reduction, depression, connectedness). In terms of the strength of the evidence, programs that have demonstrated effects on suicidal behavior (e.g., reductions in deaths, attempts) provide a higher-level of evidence, but the evidence base is not that strong in all areas. For instance, there has been less evaluation of community engagement and family programs on suicidal behavior. Thus, approaches in this package that have effects on risk or protective factors reflect the developing nature of the evidence base and the use of the best available evidence at a given time.

It is also important to note that there is often significant heterogeneity among the programs, policies, or practices that fall within one approach or strategy area in terms of the nature and quality of the available evidence. Not all programs, policies, or practices that utilize the same approach (e.g., gatekeeper training) are equally effective, and even those that are effective may not work across all populations. Tailoring programs and more evaluation may be necessary to address different population groups. The examples provided are not intended to be a comprehensive list of evidence-based programs, policies, or practices for each approach, but rather illustrate models that have been shown to impact suicide or have beneficial effects on risk or protective factors for suicide. In practice, the effectiveness of the programs, policies and practices identified in this package will be strongly dependent on the quality of their implementation and the communities in which they are implemented. Implementation guidance to assist practitioners, organizations and communities will be developed separately.

Context and Cross-Cutting Themes

The strategies and approaches that have been included in this technical package represent different levels of the social ecology, with efforts intended to impact the community and societal levels, as well individual and relationship levels. The strategies and approaches are intended to work in combination and reinforce each other to prevent suicide (see box below). The strategies are arranged in order such that those strategies hypothesized to have the greatest potential for broad public health impact on suicide are included first, followed by those that might impact more select populations (e.g., persons who have already made a suicide attempt).

Preventing Suicide	
Strategy	**Approach**
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access to mental health care	• Coverage of mental health conditions in health insurance policies
Create protective environments	• Reducing access to lethal means among persons at-risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm approaches • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning • Parenting skill and family relationship approaches
Identify and support people at risk	• Gatekeeper training • Screening combined with care management • Crisis intervention
Intervene to lessen harms and prevent future risk	• Treatment for people at-risk of suicide • Treatment to prevent re-attempts • Postvention • Safe messaging following a suicide

The example programs, policies, and practices have been implemented within particular contexts. The social and cultural context of communities is critically important to take into account when selecting strategies and approaches. Practitioners in the field may be in the best position to assess the needs and strengths of their communities and work with community members to make decisions about the combination of approaches included here that are best suited to their context.

Suicide ideation, attempts, morbidity and mortality vary by gender, race/ethnicity, age, occupation, and other important population characteristics. Barriers to disclosure, help seeking, timely access to quality care, and ongoing support may also vary by population and community characteristics. Ideally, the availability of multiple approaches tailored to the economic, cultural, and environmental context of individuals and communities are desirable as they may increase the likelihood of removing barriers to supportive and effective care and provide opportunities to develop individual and community resilience. These culturally appropriate approaches can then be included in comprehensive strategies to maximize the public health impact on reducing suicide-related morbidity and mortality among individuals and within communities.

This package includes strategies where public health agencies are well positioned to bring leadership and resources to implementation efforts. It also includes strategies where public health can serve as an important collaborator (e.g., strategies addressing community and societal level risks), but where leadership and commitment from other sectors such as business, labor or health care is critical to implement a particular policy or program (e.g., workplace policies; screening combined with care management). The role of various sectors in the implementation of a strategy or approach in preventing suicide is described further in the section on *Sector Involvement*.

In the sections that follow, the strategies and approaches with the best available evidence for preventing suicide are described.

Strengthen Economic Supports

Rationale

Studies from the U.S. examining historical trends indicate that suicide rates increase during economic recessions marked by high unemployment rates, job losses, and economic instability and decrease during economic expansions and periods marked by low unemployment rates, particularly for working-age individuals 25 to 64 years old (Luo et al., 2011; Fowler et al., 2015). Economic and financial strain, such as job loss, long periods of unemployment, reduced income, difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress, can directly increase an individual's risk for suicide or can indirectly increase risk by exacerbating related physical and mental health problems; buffering these risks can therefore, potentially protect against suicide (Stack & Wasserman, 2007). For example, strengthening economic support systems can help people stay in their homes or obtain affordable housing while also paying for necessities such as food and medical care, job training, child care, among other expenses required for daily living. In providing this support, stress and anxiety and the potential for a crisis situation may be reduced, thereby preventing suicide.

Approaches

Economic supports for individuals and families can be strengthened by targeting household financial security and ensuring stability in housing during periods of economic stress.

- **Strengthening household financial security** can potentially buffer the risk of suicide by providing individuals with the financial means to lessen the stress and hardship associated with a job loss or other unanticipated financial problems. The provision of unemployment benefits and other forms of temporary assistance, livable wages, medical benefits, and retirement and disability insurance to help cover the cost of necessities or to offset costs in the event of disability, are examples of ways to strengthen household financial security.

- **Housing stabilization policies** aim to keep people in their homes and provide housing options for those in need during times of financial insecurity. This may occur through programs that provide affordable housing such as through government subsidies or through other options available to potential homebuyers such as loan modification programs, move-out planning, or financial counseling services that help minimize the risk or impact of foreclosures and eviction.

Potential Outcomes

- Reductions in suicide rates
- Reductions in foreclosure rates
- Reductions in eviction rates
- Reductions in emotional distress

Evidence

There is evidence suggesting that strengthening household financial security and stabilizing housing can reduce suicide risk.

- **Strengthen household financial security.** An examination of variations in U.S. *unemployment benefit programs* across states demonstrated that the impact of unemployment on suicide was offset in those states that provided greater than average unemployment benefits (Cylus, Glymour, & Avendano, 2014). Another U.S. study examining the link between unemployment and suicide risk using monthly suicide data, length of unemployment, and job losses found that the duration of unemployment, as opposed to just the loss of job, predicted suicide risk (Classen & Dunn, 2012). Together, these results suggest that not only should state unemployment benefit programs be generous in their financial allocations, but also in their duration.

  Other measures to strengthen household financial security (e.g., transfer payments related to retirement and disability insurance, unemployment insurance compensation, medical benefits, and other forms of family assistance) have also shown an impact on suicide. A study by Flavin and Radcliff (2009) examined the impact of states' per capita spending on transfer payments, medical benefits, and family assistance (Temporary Assistance to Needy Families – TANF) and total state spending on suicide rates between 1990-2000, controlling for a number of suicide risk factors (e.g., residential mobility, divorce rate, unemployment rate) at the state level. As per capita spending on total transfer payments, medical benefits, and family assistance increased there was an associated decrease in state suicide rates. Moreover, it wasn't spending in general that was associated with the reduction but spending on these types of assistance. In terms of lives saved, Flavin & Radcliff calculated the cost of reducing a state's suicide rate by a full point for the years studied. At the national level, they estimated that 3,000 fewer suicides would occur per year nationwide if every state increased its per capita spending on these types of assistance by $45 per year (Flavin & Radcliff, 2009). Although this was a correlational study, the results demonstrate the potential benefits of policies that reach particularly vulnerable individuals during periods of great need and increased risk for suicide. More evaluation studies are needed to further understand the outcomes impacted by programs such as these.

- **Housing stabilization policies.** The *National Neighborhood Stabilization Program* was designed to help neighborhoods suffering from high rates of foreclosure and abandonment by slowing the deterioration of the neighborhoods and providing affordable housing options for low, moderate, and middle-income homebuyers. This program also offers financial assistance to eligible individuals for the purchase of a new home. Although this program has not been rigorously evaluated for its impact on suicide outcomes, it addresses foreclosure and eviction, which are

risk factors for suicide. A longitudinal analysis of annual data on suicides and foreclosures demonstrated that as the proportion of foreclosed properties increased in U.S. states, so did the state suicide rate, particularly among working-aged adults (Houle & Light, 2014). Another study of data from 16 U.S. states participating in the National Violent Death Reporting System found that suicides precipitated by home foreclosures and evictions increased more than 100% from 2005 (before the housing crisis began) to 2010 (after it had peaked; Fowler, Gladden, Vagi, Barnes, and Frazier (2015)). Most of these suicides occurred prior to the actual loss of the decedent's home. These findings suggest that integrating suicide prevention resources, messaging, and referrals into financial, foreclosure, and move-out planning and counseling services may help to prevent suicide.

Strengthen Access to Mental Health Care

Rationale

While most people with mental health problems do not attempt or die by suicide (Olfson, Gerhard, Huang, Crystal, & Stroup, 2015; Owens, 2002), and the level of risk conferred by different types of mental illness varies (Arsenault-Lapierre, Kim, & Turecki, 2004; E. C. Harris & Barraclough, 1997; Tyrer, Reed, & Crawford, 2015), previous research indicates that mental illness is an important risk factor for suicide (E. C. Harris & Barraclough, 1998; World Health Organization, 2014). Studies suggest that up to 90% of people who die by suicide may have had a mental illness or substance abuse problem at the time of their deaths (Arsenault-Lapierre et al., 2004; Cavanagh, Carson, Sharpe, & Lawrie, 2003; Isometsa, 2001). State-level suicide rates have also been found to be correlated with general mental health measures such as depression (Lang, 2013; Mark, Shern, Bagalman, & Cao, 2007). Findings from the National Comorbidity Survey indicate that relatively few people in the U.S. with mental health disorders receive treatment for those conditions (Kessler et al., 2005). Lack of access to mental health care is one of the contributing factors related to the underuse of mental health services (Cunningham, 2009). Identifying ways to improve access to timely, affordable, and quality mental health care for people in need is a critical component to suicide prevention (World Health Organization, 2014). Apart from the treatment benefits, it can also serve to normalize help-seeking behavior and increase the use of such services.

Approaches

One approach to strengthening access to mental health care is through the provision of mental health coverage in health insurance policies.

- **Coverage of mental health conditions in health insurance policies.** Federal and state laws include provisions for equal coverage of mental health services in health insurance plans that is on par with coverage for other health concerns (i.e., mental health parity). Benefits and services covered include such things as the number of visits, co-pays, deductibles, inpatient/outpatient services, prescription drugs, and hospitalizations. If a state has a stronger mental health parity law than the federal parity law, then insurance plans regulated by the state must follow the state parity law. If a state has a weaker parity law than the federal parity law (e.g., includes coverage for some mental health conditions but not others), then the federal parity law will replace the state law. Equal coverage does not necessarily imply good coverage as health insurance plans vary in the extent to which benefits and services are offered to address various health conditions. Rather it helps to ensure that mental health services are covered on par with other health concerns.

Potential Outcomes

- Increases in utilization of mental health services

- Reductions in symptoms of mental illnesses
- Reductions in rates of suicide attempts
- Reductions in rates of suicide

Evidence

There is evidence suggesting that coverage of mental health conditions in health insurance policies can reduce risk factors associated with suicide and may directly impact suicide rates.

- **Coverage of mental health conditions in health insurance policies.** The National Survey of Drug Use and Health is a nationally representative survey of the U.S. population that provides data on substance use, mental health conditions, and services utilization. Using data from this survey, K. M. Harris, Carpenter, and Bao (2006) found that 12 months after states enacted *mental health parity laws*, self-reported use of mental healthcare services significantly increased. Moreover, subsequent research by Lang (2013) examined state mental health laws and suicide rates between 1990 and 2004 and found that mental health parity laws, specifically, were associated with an approximate 5% reduction in suicide rates. This reduction, in the 29 states with parity laws, equated to the prevention of 592 suicides per year (Lang, 2013).

Create Protective Environments

Rationale

Prevention efforts that focus not only on individual behavior change (e.g., help-seeking, treatment interventions) but on changes to the environment can increase the likelihood of positive behavioral and health outcomes (Haddon, 1980). Creating environments that address risk and protective factors where individuals live, work, and play, can help prevent suicide (Dahlberg & Krug, 2002; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). For example, rates of suicide and suicide attempts are elevated in certain occupational groups (Han et al., 2016; McIntosh et al., 2016), therefore, changes to the organizational culture in these occupations, by way of implementation of supportive policies or even physical modifications to the workplace environment, can change social norms, encourage help-seeking, and demonstrate that good health and mental health are valued and that stigma and other risk factors for suicide are not (K. L. Knox et al., 2010; National Action Alliance for Suicide Prevention Workplace Task Force, 2015). Similarly, modifying the characteristics of the environment to prevent harmful behavior such as access to lethal means can reduce suicide rates, particularly in times of crisis (Beautrais, Gibb, Fergusson, Horwood, & Larkin, 2009; A.E. Crosby, Espitia-Hardeman, Ortega, & Lozano, 2013; Kaplan et al., 2013; Miller, Warren, Hemenway, & Azrael, 2015; C. W. Runyan et al., 2016).

Approaches

The current evidence suggests three potential approaches for creating environments that protect against suicide.

- **Reducing access to lethal means among persons at-risk of suicide.** Means of suicide such as firearms, hanging/suffocation, or jumping from heights provide little opportunity for rescue and, as such, have high case fatality rates (e.g., about 85% of people who use a firearm in a suicide attempt will die from the injury). Research also indicates that 1) the interval between thinking about and attempting suicide can be as short as 5 or 10 minutes (Deisenhammer et al., 2009; Simon et al., 2001) and 2) that people tend *not* to substitute a different method when a highly lethal method is unavailable or difficult to access (Hawton, 2007; Yip et al., 2012). Therefore, increasing the time interval between the thought and the suicide attempt, for example, by making it more difficult to access lethal means, can be lifesaving. The following are examples of approaches reducing access to lethal means for persons at-risk of suicide:

    - *Intervening at Suicide Hotspots*. Suicide hotspots, or places where suicides may take place relatively easily, include tall structures (e.g., bridges and cliffs), railway tracks, and isolated locations such as parks. Efforts to prevent suicide at these locations include

erecting barriers to prevent jumping and installing signs and telephones to encourage individuals who are considering suicide, to seek help (Cox et al., 2013).

- *Safe Storage Practices.* Safe storage of medications, firearms, and other household products can reduce the risk for suicide by separating individuals who may be vulnerable and/or impulsive from easy access to lethal means. Such practices may include education and counseling around storing firearms--locked in a secure place (e.g., in a gun safe or lock box), unloaded and separate from the ammunition--and keeping medicines in a locked cabinet or other secure location away from people who may be at risk or who have made prior attempts (Rowhani-Rahbar, Simonetti, & Rivara, 2016; C. W. Runyan et al., 2016).

- **Organizational policies and culture** that promote protective environments may be implemented in places of employment. Such policies and cultural values may promote prosocial behavior (e.g., asking for help), skill building, changing social norms, referral and access to helping services (e.g. mental health, substance abuse treatment, financial counseling), and encourage leadership support from the top down. Such policies and cultural shifts can positively impact organizational climate and morale and help prevent suicide and its related risk factors (e.g. depression, social isolation) (National Action Alliance for Suicide Prevention Workplace Task Force, 2015).

- **Community-based policies to reduce excessive alcohol use.** Research studies in the United States have found that greater alcohol availability is positively associated with alcohol-involved suicides (Escobedo & Ortiz, 2002; Giesbrecht et al., 2015). Policies to reduce excessive alcohol use broadly include zoning to limit alcohol outlet locations and density, taxes on alcohol, and bans on the sale of alcohol for individuals under the legal drinking age. These policies are important because acute alcohol use has been found to be associated with more than one-third of suicides and approximately 40% of suicide attempts (Cherpitel, Borges, & Wilcox, 2004).

Potential Outcomes

- Increases in safe storage of means
- Reductions in suicide attempts
- Reductions in suicide deaths
- Increases in help-seeking
- Reductions in alcohol-related suicide deaths

Evidence

The evidence suggests that creating protective environments can reduce suicide and suicide attempts and increase protective behaviors.

- **Reducing access to lethal means among persons at-risk of suicide.** A meta-analysis examining the impact of *suicide hotspot interventions* implemented in combination or in isolation, both in the U.S. and abroad, found associated reduced rates of suicide (Cox et al., 2013; Pirkis et al., 2015). For example, after erecting a barrier on the Jacques-Cartier bridge in Canada, the suicide rate from jumping from the bridge decreased from about 10 suicide deaths per year to about 3 deaths per year (Perron, Burrows, Fournier, Perron, & Ouellet, 2013). Moreover, the reduction in suicides by jumping was sustained even when all bridges and nearby jumping sites were considered, suggesting little to no displacement of suicides to other jumping sites (Perron et al., 2013). Further evidence for the effectiveness of bridge barriers was demonstrated by a study examining the impact of the *removal* of safety barriers from the Grafton Bridge in Auckland, New Zealand. After removal of the barrier, both the number and rate of suicide increased fivefold (Beautrais, 2001; Beautrais et al., 2009).

  Another form of means reduction involves implementation of *safe storage practices*. In a case-control study of firearm-related events identified from 37 counties in Washington, Oregon, and Missouri, and from 5 trauma centers, Grossman et al. (2005) found that storing firearms unloaded, separate from ammunition, in a locked place or secured with a safety device was protective of suicide attempts among adolescents. Further, a recent systematic review of clinic and community-based education and counseling interventions suggested that the provision of safety devices significantly increased safe firearm storage practices compared to counseling alone or compared to the provision of economic incentives to acquire safety devices on one's own (Rowhani-Rahbar et al., 2016).

  Another program, The *Emergency Department Counseling on Access to Lethal Means (ED CALM)*, trained psychiatric emergency clinicians in a large children's hospital to provide lethal means counseling and safe storage boxes to parents of patients under age 18 receiving care for suicidal behavior. In a pre-post quality improvement project, Runyan et al (2016) found that at post-test 76% (of the 55% of parents followed up, n=114) reported that all medications in the home were locked up as compared to fewer than 10% at the time of the initial emergency department visit. Among parents who indicated the presence of guns in the home at pre-test (i.e. 67%), all (100%) reported guns were currently locked up at post-test (C. W. Runyan et al., 2016).

- **Organizational policies and culture.** *Together for Life* is a workplace program of the Montreal Police Force implemented to address suicide among officers. Policy and program components were designed to foster an organizational culture that promoted mutual support and solidarity among all members of the Force. The program included training of supervisors, managers and all units to improve competencies in identifying suicidal risk and to improve use and awareness of existing resources. The program also included an education campaign to improve awareness and help-seeking (Mishara & Martin, 2012). Police suicides were tracked over 12 years and

compared to rates in the control city of Quebec. The suicide rate in the intervention group decreased significantly by 78.9% to a rate of 6.4 suicides per 100,000 population per year compared to an 11% increase in the control city (29.0 per 100,000) (Mishara & Martin, 2012).

Another example of this approach is the *United States Air Force Suicide Prevention Program (AFSPP).* AFSPP included 11 policy and education initiatives and was designed to change the culture of the Air Force surrounding suicide. The program uses leaders as role models and agents of change, establishes expectations for behavior related to awareness of suicide risk, develops population skills and knowledge (i.e., education and training), and investigates every suicide (i.e., outcomes measurement). The program represents a fundamental shift from viewing suicide and mental illness solely as medical problem and instead sees them as larger service-wide problems impacting the whole community (K. L. Knox, Litts, Talcott, Feig, & Caine, 2003). Using a time-series design to examine the impact of the AFSPP program on various violence-related outcomes, researchers found that the program was associated with a 33% relative risk reduction in suicide (K. L. Knox et al., 2003).The program was also associated with relative risk reductions in related outcomes including moderate and severe family violence (30% and 54%, respectively), homicide (51%), and accidental death (18%) (K. L. Knox et al., 2003). A longitudinal assessment of the program over the period 1981 to 2008 (16 years before the 1997 launch of the program and 11 years post-launch) found significantly lower rates of suicide after the program was launched than before (K. L. Knox et al., 2010). These effects were sustained over time, except in 2004, which the authors found was associated with less rigorous implementation in that year than in the other years (K. L. Knox et al., 2010).

- **Community-based policies to reduce excessive alcohol use.** While multiple policies to limit excessive use of alcohol exist, several studies on alcohol outlet *density*, specifically, suggest that measures to reduce alcohol outlet density can potentially reduce alcohol-involved suicides. Additionally, a longitudinal analysis of alcohol outlet density, suicide mortality, and hospitalizations for suicide attempts over 6 years in 581 California zip codes indicated that the density of bars, specifically, is related to suicide and suicide attempts, particularly in rural areas (Johnson, Gruenewald, & Remer, 2009).

Promote Connectedness

Rationale

Sociologist, Emile Durkheim theorized in 1897 that weak social bonds, i.e. lack of connectedness, are among the chief causes for suicidality (Durkheim, 1897/1951). *Connectedness* is the degree to which an individual or group of individuals are socially close, interrelated, or share resources with others (Centers for Disease Control and Prevention, 2009). Social connections can be formed within and between multiple levels of the social ecology (Dahlberg & Krug, 2002), for instance between individuals (e.g. peers, neighbors, co-workers), families, schools, neighborhoods, workplace, faith communities, cultural groups, and society as a whole. Related to connectedness, *social capital* refers to a sense of trust in one's community and neighborhood, social integration, and also the availability and participation in social organizations (Beyer, Layde, Hamberger, & Laud, 2015; Muennig, Cohen, Palmer, & Zhu, 2013). Many ecological cross-sectional and longitudinal studies have examined the impact of aspects of social capital on depression symptoms, depressive disorder, mental health more generally, and suicide. While the evidence is limited, existing studies suggest the pattern is towards a positive association between social capital measured by social trust, community/neighborhood engagement, and improved mental health. Connectedness and social capital together can serve to protect against suicidal behaviors by decreasing isolation, encouraging adaptive coping behaviors, increasing belongingness, personal value and worth all of which helps individuals to build resilience in the face of adversity. Connectedness can also provide individuals with better access to formal supports and resources, mobilize communities to meet the needs of its members and provide collective primary prevention activities to the community as a whole (Centers for Disease Control and Prevention, 2009).

Approaches

Promoting connectedness among individuals and within communities through modeling peer norms and enhancing community engagement can protect against suicide.

- **Peer norm approaches** seek to normalize protective factors for suicide such as help-seeking, reaching out and talking to trusted adults, and promote peer connectedness. These approaches typically target youth and are delivered in school settings but can also be implemented in community settings.

- **Community engagement activities**. Community engagement is an aspect of social capital. Community engagement approaches may involve residents participating in a range of activities, including religious activities, community clean-up and greening activities, and physical exercise. These activities provide opportunities for residents to become more involved in the community and to connect with other community members, organizations, and resources, resulting in enhanced overall physical health, reduced stress, and decreased depressive symptoms, thereby reducing risk of suicide.

Potential Outcomes

- Reductions in maladaptive coping attitudes and behaviors
- Increases in healthy coping attitudes and behaviors
- Increases in referrals for youth in distressed
- Increases help-seeking behaviors
- Increases in positive perceptions of adult support

Evidence

Current evidence suggests that peer norm approaches and community engagement can reduce risk factors associated with suicidal behaviors.

- **Peer norm approaches.** Evaluations show that programs such as *Sources of Strength* can improve school norms and beliefs about suicide that are created and disseminated by student peers. In a randomized controlled trial of *Sources of Strength* conducted with 18 high-schools (6 metropolitan, 12 rural), Wyman et al. (2010) found that the program improved adaptive norms regarding suicide among peer leaders, connectedness to adults, and school engagement. Peer leaders were also more likely than controls to refer a suicidal friend to an adult. For students, the program resulted in increased perceptions of adult support for suicidal youths, particularly among those with a history of suicidal ideation, and the acceptability of help-seeking behaviors. Finally, trained peer leaders also reported a greater decrease in maladaptive coping attitudes compared with untrained leaders (Wyman et al., 2010). More evaluation research is needed to examine whether these improvements in factors that protect against suicidal behavior translate into reduced suicidal behavior and suicide.

- **Community engagement activities.** A vacant lot greening initiative was undertaken in Philadelphia between 1999 and 2008. Local residents and community members worked together to green 4,436 lots (or 7.8 million square feet) in 4 areas of the city. Researchers found significant reductions in community residents' self-reported level of stress, which is a risk factor for suicide, and engagement in more physical exercise, a protective factor for suicide, than residents in control vacant lot areas. Other benefits included reductions in firearm assaults and vandalism (Branas et al., 2011).

Teach Coping and Problem-Solving Skills

Rationale

Building life skills prepares individuals to successfully tackle every day challenges and adapt to stress and adversity. Life skills encompasses many concepts, but most often include coping and problem-solving skills, conflict resolution, and critical thinking. Life skills are important in shielding individuals from suicidal behaviors (World Health Organization, 2014). Suicide prevention programs that focus on life and social skills training are drawn from social cognitive theories (Bandura, 1986), surmising that suicidal behavior is attributed to either direct learning and modeling or environmental and individual (e.g. hopelessness) characteristics. The literature linking life skills and suicide is robust. The inability to employ adequate strategies to cope with immediate stressors or identify and find solutions for problems has been characterized among suicide attempters (Pollock & Williams, 2004). Treatments that include bolstering skills (Goldsmith, Pellmar, Kleinman, & Bunney, 2002) and include problem-solving techniques (Ghahramanlou-Holloway, Bhar, Brown, Olsen, & Beck, 2012; Townsend et al., 2001) appear to reduce suicidal ideation and attempts more effectively. Prevention programs focused on teaching these skills target youth, parents and families and have been used with both universal and at-risk populations. While many do not target suicidal behaviors directly, these programs strive to train youth and parents in important life skills to offset the underlying vulnerabilities that contribute to engaging in high-risk behaviors early in life.

Approaches

Current evidence provides support for the following two approaches:

- **Social emotional learning programs** focus on developing and strengthening communication and problem-solving skills, emotion regulation, conflict resolution, help seeking and coping skills. These approaches address a range of risk and protective factors for suicidal behavior. They provide children and youth with skills to resolve problems in relationships, school, and with peers, and help youth to address other negative influences (e.g., substance use) associated with suicide. These approaches are typically delivered to all students in a particular grade or school, although some programs also focus on groups of students considered to be at high risk for suicide. Opportunities to practice and reinforce skills are an important part of programs that work (Herman, Borden, Reinke, & Webster-Stratton, 2011).

- **Parenting skill and family relationship programs** are designed to strengthen parenting skills, enhance positive parent-child interactions, and improve children's behavioral and emotional skills and abilities. Several parenting and family relationship programs have been shown in rigorous evaluations to improve resilience and reduce risk factors for various behaviors, including

ones closely related to suicide, such as depression, internalizing behaviors, and substance abuse (M. S. Knox, Burkhart, & Hunter, 2010).

Potential Outcomes

- Reductions in suicide attempts and suicide ideation
- Improvements in knowledge of risk and protective factors associated with suicide
- Reductions in suicide risk behaviors (i.e., depression, anxiety, conduct problems, substance abuse)
- Improvements in help-seeking behavior
- Improvements in social competence and emotional regulation skills
- Improvements in problem-solving and conflict management skills

Evidence

There are several programs with evidence that support teaching social, emotional and parenting skills to reduce suicidal behaviors and associated risk factors.

- **Social emotional learning programs.** The *Youth Aware of Mental Health Program (YAM)* is a program developed for teenagers aged 14-16 that uses interactive dialogue and role-playing to teach adolescents about the risk and protective factors associated with suicide (including knowledge about depression and anxiety) and enhances their problem-solving skills for dealing with adverse life events, stress, school and other problems. The program includes three hours of role-play sessions and interactive workshops combined with a booklet that students can keep, educational posters displayed in classroom, and interactive lectures about mental health at the beginning and end of the program (Wasserman et al., 2014). In a cluster-randomized controlled trial conducted across 10 European Union countries and 168 schools, students in schools randomized to YAM were significantly less likely to attempt suicide and have severe suicidal ideation at the 12-month follow-up compared to students in control schools which received educational materials and care as usual. Overall, the relative risk of youth suicide attempts among the YAM group was reduced by over 50% demonstrating that out of 1000 students, five attempted suicide in the YAM group compared to 11 in the control group. Additionally, related to severe suicide ideation, in the YAM group absolute risk fell by 0.50% and relative risk fell by 49.6% (Wasserman et al., 2014).

  Signs of Suicide (SOS) is another school-based prevention program for students aged 13-17. The program includes guided classroom discussions about suicide and depression. As part of the program, students are screened for depression and suicide risk and referred for professional help as indicated. The program is designed to increase knowledge about suicide and risk factors associated with suicidal behavior as well as improve and normalize help-

seeking behavior (Schilling, Aseltine, & James, 2016). In a randomized controlled trial, *SOS* was shown to reduce self-reported suicide attempts at 3-months post intervention among participating students compared to control students. The SOS program also increased students' knowledge of how to get help for themselves or friends for depression and/or suicidal thoughts, and favorable attitudes toward help-seeking. SOS participants with a lifetime history of suicide attempt were also less likely to report planning a suicide in the 3 months following the program compared to lower-risk participants (Schilling et al., 2016).

Finally, the *Good Behavior Game (GBG)* is a classroom-based program for elementary school children aged 6-10. The program uses a team-based behavior management strategy that promotes good behavior by setting clear expectations for good behavior and consequences for maladaptive behavior. The goal of the GBG is to create an integrated classroom social system that is supportive of all children being able to learn with little aggressive or disruptive behavior (Wilcox et al., 2008). Two cohorts of youths participated in the program in 1985-85 and 1986-86 school years when they were in the first and second grades. A number of proximal and distal outcomes were assessed among the two cohorts over time. With respect to distal suicide-related outcomes, an outcome evaluation of the *GBG* indicated that individuals in the first cohort who were assigned to participate in *GBG* when they were in the first grade reported half the adjusted odds of suicidal ideation and suicide attempts when assessed approximately 15 years later, between the ages of 19 to 21, compared to peers who had been in a standard classroom setting. The beneficial effect of the program was consistent for suicidal ideation regardless of whether baseline covariates were included. The *GBG* effect on attempts was less robust in some adjusted models including caregiver mental health. In the second cohort of *GBG* students, neither suicidal ideation nor suicide attempts were significantly different between *GBG* and the control interventions (Wilcox et al., 2008). The researchers believed this may have been due to a lack of implementation fidelity and pointed to the need for *GBG* to be delivered with precision, consistency, and teacher support. *GBG* was also found to be associated with reduced risk of later substance abuse, a risk factor for suicide (Kellam et al., 2008).

- **Parenting skill and family relationship programs.** Parenting and family skills training approaches have shown promising impacts in preventing key risk factors associated with suicide. For example, the *Incredible Years (IY)* is a comprehensive group training program for parents, teachers and children designed to reduce conduct and substance abuse problems, two important suicide risk factors, in youth by improving protective factors such as responsive and positive parent-teacher-child interactions and relationships, emotion self-regulation and social competence (all protective factors for suicide) (Herman et al., 2011). The program includes 9- 20 sessions offered in community-based settings (e.g., religious, recreation

centers, mental health treatment centers, and hospitals). Several studies have demonstrated the effect of the *IY* program on reducing internalizing symptoms, such as anxiety and depression, and child conduct problems (C. H. Webster-Stratton, Reid, & Beauchaine, 2011; Webster-Stratton, Jamila Reid, & Stoolmiller, 2008). The program is also associated with improved problem-solving and conflict management; these skills were maintained at 1-year follow-up (Reid, Webster-Stratton, & Hammond, 2003; C. Webster-Stratton & Hammond, 1997; C. Webster-Stratton, Reid, & Hammond, 2001). The program demonstrated greater benefits as the dosage of the intervention increased (Herman et al., 2011).

Additionally, *Strengthening Families 10-14* is a program that involves sessions between parents, youth, and family with the goal of improving parents' skills for disciplining, managing emotions and conflict, and communicating with their children; promoting youths' interpersonal and problem-solving skills; and creating family activities to build cohesion and positive parent-child interactions. The premise of the program is that developing these skills for both parents and children will reduce internalizing behavior and adolescent substance abuse, two important risk factors for suicide (Spoth, Guyll, & Day, 2002). *Strengthening Families* has been shown to significantly decrease externalizing behaviors, such as aggression, alcohol use, and drug use among youth participants, as well as reduce depression, alcohol use, and drug use among participating families (Spoth et al., 2002).

Identify and Support People At-Risk

Rationale

In order to decrease suicide, attention to people at increased risk is necessary, as these individuals tend to experience suicidal behavior at higher than average rates. These vulnerable or disadvantaged populations include, but are not limited to, individuals with lower socio-economic status or who are living with a mental health problem; people who have attempted suicide previously; individuals who are institutionalized, have been victims of violence, or are homeless; and members of certain racial and ethnic minority groups. Supporting these vulnerable groups requires proactive case finding along with access to, and retention in, mental health services. Finding effective ways of identifying at-risk or vulnerable groups, customizing services to make them accessible and engaged in care remain key challenges. For example, simply improving services does not guarantee that those services will be used by those most in need of them, nor will it necessarily increase the number of people who follow treatments that are recommended. People who are disadvantaged face social and economic issues that may adversely affect their ability to respond to the treatments or advice that are offered.

Approaches

The following three approaches focus on identifying and supporting people at increased risk.

- **Gatekeeper training** is designed to train teachers, coaches, providers and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating treatment seeking and support services. Gatekeeper training is typically implemented in schools to identify at-risk youth and within health care settings to identify adults (and youth).

- **Screening combined with care management and overall continuity of care** has been used in primary care and behavioral health care settings to assure that people who may be at high-risk of suicide are identified and receive ongoing treatment as needed, particularly after inpatient discharge and other transitions within the healthcare system so they don't 'slip through the cracks'. These approaches typically employ screening for depression and/or suicide combined with collaborative treatment planning between patients and their providers and patient follow-up.

- **Crisis intervention**. These approaches provide support and referral services, typically by connecting a person in crisis (or a friend or family member of someone at-risk) to trained volunteers or professional staff via telephone hotline, online chat, or text messaging. Crisis intervention approaches are intended to impact key risk factors for suicide, including feelings of depression, hopelessness, and subsequent mental health care utilization. Like means reduction,

crisis interventions can put space or time between an individual who may be considering suicide and harmful behavior.

Potential Outcomes

- Reductions in suicide attempts
- Reductions in suicide deaths
- Increases in identification of individuals at-risk for suicidal behavior
- Increases in at-risk individuals in treatment
- Increases in community members trained to identify at-risk individuals
- Increases in referrals for health care

Evidence

The current evidence suggests that identifying people at risk of suicide and the continued provision of support for these individuals can positively impact both suicide risk factors as well as suicide mortality.

- **Gatekeeper training**. One example of gatekeeper training is the *Mental Health First Aid (MHFA)* program. This program is designed for the lay public and consists of three weekly sessions of three hours each. Participants learn the symptoms of people in mental health crises and/or in the early stages of mental health problems (i.e., those experiencing suicidal thoughts and behavior, acute stress reaction, panic attacks and acute psychotic behavior, and depression, anxiety, and psychotic disorders), possible risk factors, and where and how to get effective help (Kitchener & Jorm, 2004). In a randomized controlled trial of 301 participants of *MHFA*, the intervention group, compared to the wait-listed control group, reported at 5 months follow-up, significantly greater feelings of confidence in helping someone (74.5% vs. 57.4%, $p<.001$), greater likelihood of encouraging people to seek professional help (29.4% vs. 16.8%, $p<.01$), improved agreement with health professionals about treatments ($p<.04$), and decreased stigmatizing attitudes towards mental illness ($p<.02$). Additionally, the intervention resulted in improved overall mental health of the participants themselves ($p<.04$). However, the percent who provided some or a lot of help did not differ between groups (Kitchener & Jorm, 2004). Additional research rigorously evaluating *MHFA* for its impact on intervention recipients' suicidal behavior is needed (Kitchener & Jorm, 2006).

  Gatekeeper training has also been a primary part of all *Garret Lee Smith (GLS) Suicide Prevention Program* which is in place in 49 states and 48 tribes. A multi-site evaluation assessed the impact of community gatekeeper training on suicide attempts and deaths by comparing the change in suicide rates and nonfatal suicidal behavior among young people aged 10-24 in counties

implementing *GLS* trainings, with the trajectory observed in similar counties that did not implement these trainings. Counties that implemented *GLS* trainings had significantly lower youth suicide rates one year following the training implementation (Walrath, Garraza, Reid, Goldston, & McKeon, 2015). This finding equates to a decrease of 1 suicide death per 100,000 among youth ages 10 to 24, or the prevention of approximately 237 deaths in the age group, between 2007 and 2010. Counties implementing *GLS* program activities, including gatekeeper training, also had significantly lower suicide attempt rates among youth ages 16 to 23 in the year following implementation of the *GLS* program than did similar counties that did not implement *GLS* activities (4.9 fewer attempts per 1000 youths; Godoy Garraza, Walrath, Goldston, Reid, & McKeon, 2015). More than 79,000 suicide attempts may have been prevented during the period examined, following implementation of the *GLS* program.

Comment [A]: The extra parenthetical is not necessary. Could cite as (...4.9 fewer attempts per 1000 youths; Garraza,et al., 2015).

Comment [A]: Done.

- **Screening combined with care management and overall continuity of care.** The *Henry Ford* healthcare system is a large health maintenance organization (HMO) in the state of Michigan. *Henry Ford's Perfect Depression Care* program was the pre-cursor to what is now called *Zero Suicide*, and its overall goal was to eliminate suicide among its members. More broadly, the goal of the program was to redesign delivery of depression care to achieve "breakthrough improvement" in quality and safety by focusing on effectiveness, safety, patient centeredness, timeliness, efficiency, and equity among patients. The program screened and assessed each patient for suicide risk and implemented coordinated continuous follow-up care system wide (C. E. Coffey, 2006). An examination of the impact of the program found that there was a dramatic and statistically significant decrease in the rate of suicide between the baseline years, 1999 and 2000, prior to the intervention to the intervention years, 2002-2009. During this time period, the suicide rate fell by 82% (C. E. Coffey, 2006; C. E. Coffey, Coffey, & Ahmedani, 2013). Further, among HMO members who received mental health specialty services, the suicide rate significantly decreased over time from 1999 to 2010 (110.3 to 47.6 per 100,000; $p<.04$) with a mean of 36.2 per 100,000 over the period. Additionally, for those HMO members who accessed only general medical services as opposed to specialty mental health services, the suicide rate increased from 2.7 to 5.6 per 100,000 ($p<.01$). Similarly, in the state of Michigan, rates of suicide in the general population increased over the period from 9.8 to 12.5 per 100,000 ($p<.001$) (M. Coffey, Coffey, & Ahmedani, 2015).

- **Crisis intervention.** Suicide prevention hotlines are one way to provide crisis intervention. In an evaluation of the effectiveness of the *National Suicide Prevention Lifeline (NSPL)* to prevent suicide, 1,085 suicidal individuals who called the hotline completed a standard risk assessment for suicide, and 380 of those completed a follow-up assessment between 1 and 52 days (mean=13.5 days) after the initial assessment. Researchers found that over half of the initial sample were seriously considering suicide when they called, and they had a plan for their suicide.

Researchers also found that among follow-up participants, there was a significant decrease in psychological pain, hopelessness, and intent to die between initiation of the call (time 1) to follow-up (time 3). Between time 2 (end of the call) to time 3, the effect remained for psychological pain and hopelessness, but was not significant for intent to die (Gould, Kalafat, Harrismunfakh, & Kleinman, 2007).

In another study, this time employing a randomized controlled trial, Gould, Cross, Pisani, Munfakh, and Kleinman (2013) assessed the impact of the *Applied Suicide Intervention Skills Training (ASIST)*, a widely implemented training program that helps hotline counselors, emergency workers, and other gatekeepers to identify and connect with suicidal individuals, understand their reasoning for living and dying, and assist with safely connecting those in need to available resources. The training was evaluated across the NSPL network of hotlines over the period 2008-2009 (Gould et al., 2013). Using data from 1,410 suicidal individuals who called 17 Lifeline centers, the researchers found that compared to callers who spoke to counselors that received the usual care training, individuals who spoke with counselors without training in *ASIST* were significantly more likely to feel depressed, suicidal, more overwhelmed, and less hopeful by the end of their call to the hotline compared to those with training in *ASIST*. Counselors trained in *ASIST* were also more skilled at keeping callers on the phone longer and establishing a connection with them. However, training in *ASIST* did not result in more comprehensive suicide risk assessments than usual care training (Gould et al., 2013).

Intervene to Lessen Harms and Prevent Future Risk

Rationale

Individuals who have experienced mental health challenges, suicidal ideation, who have made suicide attempts or engaged in non-suicidal self-injury are at increased risk of suicide (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Risk of suicide can also increase among those who have lost a friend, family member, co-worker, or other acquaintance to suicide (Pitman, Osborn, King, & Erlangsen, 2014). Exposure to sensationalized or uninformed reporting regarding on suicide may heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion (Etzersdorfer & Sonneck, 1998; Niederkrotenthaler & Sonneck, 2007).

Approaches

There are a number of approaches that can be used to lesson harms and reduce future risk of suicide including various therapeutic treatments and approaches providing continuity of care, caring for the bereaved, and safe messaging around suicide.

- **Treatment for people at-risk of suicide** typically includes various forms of psychotherapy delivered by licensed providers to help individuals with mental health problems and other risk factors for suicide with problem-solving, impulsivity and emotion regulation. Treatment usually takes place in a one on one or group format between patients and clinicians in mental healthcare settings and can vary in duration from several weeks to ongoing therapy for years in some cases.

- **Treatment to prevent re-attempts.** These approaches typically include follow-up contact and use diverse modalities (e.g., home visits, mail, telephone, e-mail) to engage recent suicide attempt survivors in continued treatment to prevent re-attempts. Treatment may focus on improved coping skills, mindfulness, and other emotional regulation skills, and may include case management home visits to increase adherence to treatment and continuity of care; and one-on-one interpersonal therapy and/or group therapy. Approaches that engage and connect attempters to peers and providers are especially important because many attempters do not present to aftercare; 12%-25% reattempt within a year, and 3%-9% of attempt survivors die by suicide within 1 to 5 years of their initial attempt (Inagaki et al., 2015)

- **Postvention** approaches are implemented *after* a suicide has taken place and may include debriefing sessions, counseling, and/or bereavement support groups for surviving friends and family members/loved ones. These programs have not typically been evaluated for their impact on suicide or suicidal behavior but may reduce survivors' guilt, feelings of depression, and complicated grief (Szumilas & Kutcher, 2011).

- **Safe messaging following a suicide.** The manner in which information on a recent suicide is communicated to the public (e.g. school assemblies, mass media, social media) can heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion. Therefore, responsible and safe reporting may help prevent suicide and suicide contagion.

Potential Outcomes

- Reductions in mental health-related sequelae
- Increases in connectedness
- Improvements in coping skills
- Improvements in messaging following suicide
- Reductions in re-attempts
- Reductions in contagion effects related to suicide

Evidence

Current evidence suggests that therapeutic treatments and other approaches for lessening harm can impact risk and protective factors for suicide.

- **Treatment for people at-risk of suicide**. One example of a treatment with evidence of impact on risk and protective factors for suicide is the *Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)* program. *IMPACT* aims to prevent suicide among older primary care patients by reducing suicide ideation and depression in primary care settings. It facilitates the development of a therapeutic alliance, a personalized treatment plan that includes patient preferences, as well as proactive follow-up (biweekly during an acute phase and monthly during continuation phase) by a depression care manager (Hunkeler et al., 2006). The program has been shown to significantly improve quality of life, and to reduce functional impairment, depression and suicidal ideation over 24-months of follow-up (Hunkeler et al., 2006; Unutzer et al., 2006) relative to patients who received care as usual.

  Another example is *Collaborative Assessment and Management of Suicidality (CAMS)*, which is a therapeutic approach for suicide-specific assessment and treatment of patient's suicide risk. This flexible approach can be used across treatment settings and clinician theoretical orientations and involves the clinician and patient working together in an interactive assessment process to develop patient-specific treatment plans. *CAMS* sessions are collaborative and involve constant patient input about what is and is not working with the ultimate goal of enhancing the

therapeutic alliance and increasing treatment motivation in the suicidal patient. *CAMS* been tested and supported in 6 correlational studies (Jobes, 2012), in a variety of inpatient and outpatient settings and in one RCT with several additional RCTs under way. *CAMS* has been associated with significant improvements in suicidal ideation, overall symptom distress, and feelings of hopelessness at 12 month follow-up among a community-based sample of suicidal outpatients. (Comtois et al., 2011).

Other examples include *Dialectical Behavioral Therapy (DBT)* and *Attachment-Based Family Therapy (ABFT). DBT* is a multicomponent therapy for individuals at high risk for suicide and who may struggle with impulsivity and emotional regulation. The components of *DBT* include individual therapy, group skills training, between-session telephone coaching and a therapist consultation team. In a randomized controlled trial of women with recent suicidal or self-injurious behavior, those receiving *DBT* were half as likely to make a suicide attempt at two-year follow-up than women receiving community treatment (23% vs 46%), required less hospitalization for suicide ideation, and had lower medical risk across all suicide attempts and self-injurious acts combined (Linehan et al., 2006).

ABFT is a program for adolescents aged 12-18 and is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety (Diamond et al., 2010). A randomized controlled trial of ABFT found that suicidal adolescents assigned to *ABFT* experienced significantly greater improvement in suicidal ideation over 24 weeks of follow-up than did adolescents assigned to enhanced usual care. Additionally, a significantly higher percentage of *ABFT* participants reported no suicidal ideation in the week prior to assessment at 12 weeks than did adolescents receiving enhanced usual care (69.2% vs. 34.6%) and at 24 weeks (82.1% vs. 46.2%) (Diamond et al., 2010).

- **Treatment to prevent re-attempts.** Several strategies that aim to prevent re-attempts have demonstrated impact on reducing suicidal behavior. For example, *Emergency Department Brief Intervention with Follow-up Visits* is a program that involves a one-hour discharge information session that addresses suicidal behavior, distress, risk and protective factors, alternatives to suicidal behavior, and referral options, combined with nine follow-up contacts over 18 months (at 1, 2, 4, 7, 11 weeks and 4, 6, 12, 18 months). Follow-up contacts are either conducted by phone or through home visits according to a specific time line for up to 18-months. A randomized controlled trial that enrolled suicide attempters from eight hospital emergency departments in five countries (Brazil, India, Sri Lanka, Iran, and China) found that a brief intervention combined with 9 follow-up visits over 18-months was associated with significantly fewer deaths from suicide relative to a treatment-as-usual group (0.2% versus 2.2%, respectively) (Fleischmann et al., 2008).

Another example of treatment to prevent re-attempts involves *active follow-up contact approaches* such as postcards, letters, and telephone calls intended to increase a patient's sense of connectedness with health care providers and decrease isolation. These approaches include expression of care and support and typically invite patients to reconnect with their provider. Contacts are made periodically (e.g., monthly or every few months in the first 12 months post-discharge with some programs continuing contact for two or more years). In a meta-analysis conducted by Inagaki et al. (2015), interventions to prevent repeat suicidal behavior in patients admitted to an emergency department for suicide attempt were found to reduce reattempts by approximately 17% for up to 12 months post-discharge; however, the effects of these approaches beyond 12 months on reattempts has not yet been demonstrated. Also, because the number of trials and associated sample sizes included in this meta-analysis were small, it was not possible to determine the effect of active contact and follow-up approaches on death by suicide. In a randomized controlled trial of the post-crisis suicide prevention long-term follow-up contact approach, Motto and Bostrom (2001) found that patients who refused ongoing care but who were randomized to be contacted by letter four times per year had a lower rate of suicide over two years of follow-up than did patients in the control group who received no further contact. Other studies have also shown post-crisis letters and coping cards to be protective against suicide ideation and attempts (Hassanian-Moghaddam, Sarjami, Kolahi, & Carter, 2011; Wang et al., 2016).

Finally, *Cognitive Behavior Therapy for Suicide Prevention (CBT-SP*) is an example of a therapeutic approach to prevent re-attempts. It uses a risk-reduction, relapse prevention approach that includes an analysis of proximal risk factors and stressors (e.g., relationship problems, school or work-related difficulties) leading up to and following the suicidal event; safety plan development; skill building; and psychoeducation. *CBT-SP* also has family skill modules focused on family support and communication patterns as well as improving the family's problem solving skills. A randomized controlled trial of *CBT-SP* found that 10-session outpatient cognitive therapy designed to prevent repeat suicide attempts resulted in a 50% reduction in the likelihood of a suicide reattempt among adults who had been admitted to an emergency department for a suicide attempt relative to treatment as usual (Brown et al., 2005).

- **Postvention** programs are implemented with the goal of providing support to survivors of others' suicide to reduce their own risk of suicide. One example of a postvention program, *StandBy Response Service* (*StandBy),* provides clients with face-to-face outreach and telephone support through a professional crisis response team. Site coordinators develop customized case management plans, referring clients to other existing community services matched to their needs (Visser, Comans, & Scuffham, 2014). In a study by Visser et al. (2014), *StandBy* clients were significantly less likely to be at high risk for suicidality than a suicide bereaved comparison group

who had not had contact with the *StandBy* program (48% and 64% respectively). Additionally, research suggests that active postvention approaches in which outreach to suicide survivors occurs at the scene of a suicide is associated with intake into treatment sooner, greater attendance at support group meetings, and attendance at more meetings compared to passive postvention (versus passive approaches where survivors self-refer for services) (J. Cerel & Campbell, 2008).

- **Safe messaging following a suicide.** Safe messaging after a suicide can help assure that reporting of the event is done in such a way to reduce risk to consumers of news media and other messaging who may be particularly vulnerable. One way to ensure safe messaging following a suicide is to encourage that reporters adhere to *Recommendations for Reporting on Suicide* (http://www.reportingonsuicide.org). Reports that are both inclusive of suicide prevention messages, stories of hope and resilience, risk and protective factors, and links to helping resources (e.g., hotline) and that avoid sensationalizing events or reducing suicide to one cause can help reduce the likelihood of suicide contagion. The most compelling evidence supporting these recommendations for reporting comes from Austria. After a sharp increase in suicides on the Viennese subway, media guidelines were introduced and an interrupted time series design was used to evaluate the national impact of the guidelines on subsequent suicides. Changes in the quality and quantity of media reporting resulted in a nationwide significant reduction of 81 suicides annually (Niederkrotenthaler & Sonneck, 2007). Finally, research suggests that not only does reporting on suicide in a negative way (e.g., reporting on suicide myths and repetition) have harmful effects on suicide, but reporting on positive coping skills in the face of adversity can also demonstrate protective effects against suicide (Niederkrotenthaler et al., 2010). Reports of individual suicidal ideation not accompanied by reports of suicide or suicide attempts, along with reports describing a "mastery" of a crisis situation where adversities were overcome, was associated with significant decreases in suicide rates in the time period immediately following such reports (Niederkrotenthaler et al., 2010).

Sector Involvement

Public health can play an important and unique role in addressing suicide. Public health agencies, which typically place prevention at the forefront of efforts and work to create broad population-level impact, can bring critical leadership and resources to bear on this problem. For example, these agencies can serve as a convener, bringing together partners and stakeholders to plan, prioritize, and coordinate suicide prevention efforts. Public health agencies are also well positioned to collect and disseminate data, implement preventive measures, evaluate programs, and track progress. Although public health can play a leadership role in preventing suicide, the strategies and approaches outlined in this technical package cannot be accomplished by the public health sector alone. As noted in the National Strategy to Prevent Suicide, the integration and coordination of prevention activities across sectors and settings is critical for expanding the reach and impact of suicide prevention efforts.

Other sectors vital to implementing this package include, but are not limited to, education, government (local, state, and federal), social services, health services, business, labor, justice, housing, media, and organizations that comprise the civil society sector such as faith-based organizations, youth-serving organizations, foundations, and other non-governmental organizations. Collectively, these sectors can make a difference in preventing suicide by impacting the various contexts and underlying risks that contribute to suicide.

The strategies and approaches described in this technical package are summarized in Appendix A along with the relevant sectors that are well positioned to lead implementation efforts. For example, business and labor, health care insurers and providers, and government entities are in the best position to implement programs and policies that *Strengthen Economic Supports* and *Access to Mental Health Care*. These types of supports go beyond individual behavior change and require commitment and support from those sectors that can directly address some of the underlying risks and the environmental contexts that increase the risk for suicide. Public health entities can play an important role by gathering and synthesizing information to inform policy, raise awareness, and evaluate the effectiveness of various policies. Moreover, partnerships with non-governmental and community organizations can be instrumental in increasing awareness of and garnering support for policies affecting individuals and families.

The public health sector has been at the forefront of many community-based prevention efforts, working collaboratively with schools and community-based organizations, to change social norms and positively impact health behavior. Public health is well suited to take on a similar leadership role in *Promoting Connectedness* through peer norm and community engagement activities and supporting the development, evaluation, and adoption of effective programs that *Teach Coping and Problem-Solving Skills* to prevent suicide from happening in the first place. These programs are often delivered in school and community settings, making education and non-governmental organizations vital partners in prevention.

Businesses, workplaces, and local and state government entities, on the other hand, are in the best position to establish policies and support practices that *Create Protective Environments* where people live, work, and play. Public health entities can play an important role by gathering and synthesizing information, working with other agencies within the executive branch of their state or local government in support of policy and other approaches, and evaluating the effectiveness of measures taken. In a similar fashion, public health entities can partner with schools, workplaces, and community organizations to implement and evaluate prevention programs, policies and practices geared toward creating safe, healthy, and supportive environments.

Finally, this technical package includes a number of interventions delivered in hospital, primary care, behavioral health care, and community settings designed to *Identify and Support People At-Risk* and to *Lessen Harms and Prevent Future Risk*. The intensity and activities of these interventions require the expertise of professionals who are licensed and trained to deliver critical intervention support. The health care, social services, and justice sectors can work collaboratively to support individuals at high-risk for suicide and their families. These activities also require coordination of supports across various service providers and community organizations.

Regardless of strategy, action by many sectors will be necessary for the successful implementation of this package. In this regard, all sectors can play an important and influential role in preventing suicide from happening in the first place and lessening the immediate and long-term harms of suicidal behavior by helping those in times of crisis get the services and support they need.

Monitoring and Evaluation

Monitoring and evaluation are necessary components of the public health approach to prevention. It is important to have timely and reliable data to monitor the extent of the problem and to evaluate the impact of prevention efforts. Data are necessary for program implementation as planning, implementation, and assessment all rely on accurate measurement of the problem.

Surveillance data helps researchers and practitioners track changes in the burden of suicide. Surveillance systems exist at the federal, state, and local levels. It is important to assess the availability of surveillance data and data systems across these levels to identify and address gaps in the systems. CDC's National Vital Statistics System and the National Violent Death Reporting System (NVDRS) are examples of surveillance systems that provide data on deaths from suicide. NVDRS, for example, is a state-based surveillance system that combines data from death certificates, law enforcement reports, and coroner or medical examiner reports to provide detailed information on the circumstances of violent deaths, including suicide, which can assist communities in guiding prevention approaches (Blair, Fowler, Jack, & Crosby, 2016). The National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP) provides nationally representative data about all types and causes of nonfatal injuries treated in U.S. hospital emergency departments, and can be used to assess national rates of, and trends in, self-harm injuries by cause (e.g., falls, poisoning, etc.), age, race/ethnicity, sex, disposition (where the injured person goes when released from the Emergency Department).

In addition to information on deaths and nonfatal injuries, there are also surveillance systems that provide national, state, and some local estimates of suicidal behavior. The Youth Risk Behavior Surveillance System (YRBSS) collects information from a nationally representative sample of 9-12 grade students and is a key resource in monitoring health-risk behaviors among youth, including whether youth have seriously considered attempting suicide, attempted suicide, made a plan, or required treatment by a doctor or nurse for a suicide attempt that resulted in an injury, poisoning, or overdose (Brener et al., 2013). The YRBSS data are obtained from a national school-based survey conducted by CDC as well as from state, territorial, tribal, and large urban school district surveys conducted by education and health agencies. The National Survey on Drug Use and Health (NSDUH) is an annual survey of the civilian, non-institutionalized population aged 12 years and older. NSDUH provides both national and state-level estimates of substance use (alcohol, tobacco, illicit drugs, and non-medical use of prescription drugs); mental health (past year mental illness, co-occurring illnesses); and service utilization, along with suicide ideation, suicide plans, and suicide attempts. NSDUH is a key resource to track trends in suicide-related risk factors in the population and to help identify groups at increased risk.

It is also important at all levels (local, state, and federal) to address gaps in responses, track progress of prevention efforts and evaluate the impact of those efforts, including the impact of this technical package. Evaluation data, produced through program implementation and monitoring, is essential to provide information on what does and does not work to reduce rates of suicide and its associated risk

and protective factors. Theories of change and logic models that identify short, intermediate, and long-term outcomes are an important part of program evaluation.

The evidence-base for suicide prevention has advanced greatly over the last few decades. However, additional research is needed to understand the impact of programs, policies, and practices on suicide (and suicide attempts, at a minimum), as opposed to merely examining their effectiveness on risk factors. More research is also needed to examine the effectiveness of primary prevention strategies (before risk occurs) and community-level strategies to prevent suicide at the population level. Lastly, it will be important for researchers to test the effectiveness of combinations of the strategies and approaches included in this package. Most existing evaluations focus on approaches implemented in isolation, but there is potential to understand the synergistic effects within a comprehensive prevention approach.

Conclusion

Suicide is a serious public health problem whose rates have been on the rise for more than a decade and whose costs stretch well into the billions of dollars each year. While suicide is a rare outcome statistically, its human impact has a ripple effect that is far-reaching. Each of us likely interacts with suicide survivors, those with lived experience, and those with thoughts of suicide, on a daily basis--at home, at work, and in our communities. Suicide and suicide attempts are therefore public health issues of societal concern. Fortunately, like many public health problems, suicide is preventable, and more is being done to prevent suicide than ever before, as evidenced by the work of the National Action Alliance for Suicide Prevention, the release of the first world report on suicide, and more timely surveillance data, to name just a few examples. Unfortunately, suicide prevention is impeded by barriers including: stigma related to help-seeking, mental illness, being a survivor, or someone with lived experience; fear related to asking about suicidal thoughts, hesitation to take up strategies known to be effective but perhaps unpopular; misinformation about suicide preventability, harmful messaging about suicide, and disproportionate funding given its public health burden.

In an effort to continue pushing the field and society further towards prevention, this technical package includes strategies and approaches that ideally would be used in a comprehensive, multi-level and multi-sectoral way. This technical package includes strategies and approaches to prevent suicide from occurring in the first place, as well as strategies focused on lessening the immediate and long-term harms of suicidal behavior. It includes strategies that range from a focus on the whole population regardless of risk to strategies designed to support people at highest risk. Importantly, this technical package extends the bounds of the typical prevention strategies to consider approaches that go beyond individual behavior change to better address risk factors impacting communities and populations more broadly (e.g., policies to stabilize housing and community engagement initiatives).

Comment [A]: This is a very long sentence. Suggest breaking it up a bit. I also don't believe we will be able to keep the piece about funding as we can't specifically call for funding.

Comment [A]: Tried to tighten the sentence up further.

While the evidence base continues to emerge, the collection of programs, policies, and practices laid out here are available for implementation now. And in keeping with good public health practice, the intent is that monitoring and evaluation will play a key role in that implementation. Moreover, as new evidence becomes available, this technical package can be refined to reflect the current state of the science.

In closing, and in keeping with a message of resilience as spoken by those with lived experience, 'hope, help, and healing is possible.'

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Appendix A: Summary of Strategies and Approaches to Prevent Suicide

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		Suicide	Suicide Attempts or Ideation	Other Risk/Protective Factors for Suicide	
Strengthen economic supports	**Strengthen household financial security**				Government (local, state, Federal) Business/labor
	Unemployment benefit programs	✓			
	Other income supports	✓			
	Housing stabilization policies				Government (local, state, Federal)
	The National Neighborhood Stabilization Program			✓	
Strengthen access to mental health care	**Coverage of mental health conditions in health insurance policies**				Health care Government (state, Federal)
	Mental Health Parity Laws	✓		✓	
Establish protective environments	**Reducing access to lethal means among persons at-risk**				Government (local, state) Public Health
	Intervening at suicide hot spots	✓			
	Safe storage practices		✓	✓	
	Organizational policies and culture				Business/Labor Government (local, state, Federal)
	Together for Life	✓			
	US Air Force Suicide Prevention Program	✓		✓	

		Best Available Evidence			
	Community-based policies to reduce excessive alcohol use				Government (local, state) Business/labor
	Alcohol outlet density	✓		✓	
Promote connectedness	**Peer norm approaches**				Public Health Education
	Sources of Strength			✓	
	Community-engagement activities				Public Health Government (local)
	Greening vacant urban spaces			✓	
Teach coping and problem-solving skills	**Social emotional learning**				Public Health Education
	Youth Aware of Mental Health Program		✓		
	Signs of Suicide		✓	✓	
	Good Behavior Game		✓	✓	
	Parenting skill and family relationship approaches				Public Health Education
	The Incredible Years			✓	
	Strengthening Families 10-14			✓	
Identify and	**Gatekeeper training**				Public Health Healthcare
	Mental Health First Aid			✓	
	Screening combined with care management				Healthcare

		Best Available Evidence			
support people at-risk	*Henry Ford Perfect Depression Care (Precursor to Zero Suicide)*	✓		✓	Social Services
	Crisis Intervention				Public Health
	National Suicide Prevention Lifeline		✓	✓	Social Services
	Applied Suicide Intervention Skills Training		✓	✓	
Intervene to lessen harms and prevent future risk	**Treatment for people at risk of suicide**				Healthcare
	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)		✓	✓	Social Services Justice
	Collaborative Assessment and Management of Suicidality (CAMS)		✓	✓	
	Dialectical Behavioral Therapy		✓	✓	
	Attachment-Based Family Therapy		✓		
	Treatment to prevent re-attempts				Healthcare
	ED Brief Intervention with Follow-up Visits	✓			Social Services
	Active follow-up contact approaches	✓	✓		
	CBT for Suicide Prevention				
	Postvention				Healthcare

		Best Available Evidence			
	StandBy Response Service		✓		
	Safe messaging following a suicide				Public Health Media
	Media Guidelines	✓			

[1]This column refers to the lead sectors well positioned to bring leadership and resources to implementation efforts. For each strategy, there are many other sectors such as non-governmental organizations that are instrumental to prevention planning and implementing the specific programmatic activities.

Preventing Suicide:
A Technical Package of Policy, Programs, and Practices

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Overview

This technical package represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide. These strategies include strengthening economic supports; strengthening access to mental health care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at-risk; and intervening to lessen harms and prevent future risk. The strategies represented in this package include those with a focus on preventing suicide from happening in the first place as well as approaches to lessen the immediate and long-term harms of suicidal behavior for individuals, families, communities, and society. The strategies in the technical package support the goals and objectives of the National Strategy for Suicide Prevention and the National Action Alliance for Suicide Prevention's priority to strengthen community-based prevention. Commitment, cooperation, and leadership from numerous sectors, including public health, education, justice, health care, social services, business, labor, and government can bring about the successful implementation of this package.

What is a Technical Package?

A technical package is a compilation of a core set of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome (Frieden, 2014). Technical packages help communities and states prioritize prevention activities based on the best available evidence. This technical package has three components. The first component is the ***strategy*** or the preventive direction or actions to achieve the goal of preventing suicide. The second component is the ***approach***. The approach includes the specific ways to advance the strategy. This can be accomplished through *programs, policies, and practices*. The approaches included come primarily from studies based in the United States. The ***evidence*** for each of the approaches in preventing suicide or its associated risk factors is included as the third component. This package is intended as a resource to guide and inform prevention decision-making in communities and states.

Preventing Suicide is a Priority

Suicide, as defined by the Centers for Disease Control and Prevention (CDC), is part of a broader class of behavior called *self-directed violence*. Self-directed violence refers to behavior directed at oneself that deliberately results in injury or the *potential* for injury (A.E. Crosby, Ortega, & Melanson, 2011). Self-directed violence may be *suicidal* or *non-suicidal* in nature. For the purposes of this document, we refer only to behavior where suicide is intended:

- **Suicide** is a death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

- **Suicide attempt** is defined as a *non-fatal* self-directed and potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicide is highly prevalent. Suicide presents a major challenge to public health in the United States and worldwide. It contributes to premature death, morbidity, lost productivity, and health care costs (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014). In 2014 (the most recent year of available death data), suicide was responsible for 42,773 deaths in the U.S., which is approximately one suicide every 12 minutes (Centers for Disease Control and Prevention, 2016d). In 2014, suicide ranked as the 10th leading cause of death and has been among the top 12 leading causes of death since 1975 in the U.S (Centers for Disease Control and Prevention, 2016d). Overall suicide rates have increased 24% from 1999 to 2014 (Curtin, Warner, & Hedegaard, 2016). Suicide is a problem throughout the life span; it is the second leading cause of death among those aged 10–34 years; it is the fourth leading cause among persons in their 40s and seventh among persons in their 50s. Suicide rates vary by race/ethnicity with the highest rates, across the lifespan, occurring among non-Hispanic American Indian/Alaska Native (AI/AN) (rate: 17.8/100,000). Among AI/AN, young people are disproportionately at increased risk of suicide with young males aged 25-29 experiencing the highest rates (rate: 56.9/100,000). Moreover, suicide rates among non-Hispanic AI/AN have increased by 48.7% since 1999 (Centers for Disease Control and Prevention, 2016d).

Suicides reflect only a portion of the problem (A.E. Crosby, Han, Ortega, Parks, & Gfroerer, 2011). Substantially more people are hospitalized as a result of nonfatal suicidal behavior (i.e. suicide attempts) than are fatally injured, and an even greater number are either treated in ambulatory settings (e.g., emergency departments) or not treated at all (A.E. Crosby, Han, et al., 2011). For example, during 2014, among adults aged 18 years and older, for every one suicide there were 9 adults treated in hospital emergency departments for self-harm injuries, 27 who reported making a suicide attempt, and over 227 who reported seriously considering suicide (i.e. ideation) (Ferdon et al., In press).

Suicide is associated with several risk and protective factors. Suicide, like other human behaviors, has no single determining cause. Instead, suicide occurs in response to multiple biological, psychological, interpersonal, environmental and societal influences that interact with one another, often over time. The social-ecological model-- encompassing multiple levels of focus from the individual, relationship, community, and societal-- is a useful framework for viewing and understanding suicide risk factors identified in the literature (Dahlberg & Krug, 2002). Risk and protective factors for suicide exist at each level. For example, risk factors include:

- **Individual level**: History of depression and other mental illnesses, hopelessness, substance abuse, certain health conditions, previous suicide attempt, violence victimization and perpetration, and genetic and biological determinants
- **Relationship level**: High conflict or violent relationships, sense of isolation and lack of social support, family/loved one's history of suicide, financial and work stress

- **Community level**: Inadequate community connectedness, barriers to health care (e.g., lack of access to providers and medications)
- **Societal level**: Availability of lethal means of suicide, unsafe media portrayals of suicide, stigma associated with help-seeking and mental illness (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014).

It is important to recognize that the vast majority of individuals who are depressed or who have other risk factors noted, do *not* die by suicide. Furthermore, the relevance of each risk factor can vary by age, race, gender, sexual orientation, residential geography, and socio-cultural and economic status (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014).

Protective factors, or those influences that guard *against* the risk for suicide, can also be found across the different levels of the social-ecological model. Protective factors identified in the literature include: effective coping and problem solving skills, moral objections to suicide, strong and supportive relationships with partners, friends, and family; connectedness to school, community and other social institutions; availability of quality and ongoing physical and mental health care, and reduced access to lethal means (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014). These protective factors can either counter a specific risk factor or guard against a number of risks associated with suicide.

Suicide is connected to other forms of violence. Suicide and other forms of violence often share some of the same root causes (Butchart, Phinney, Check, & Villaveces, 2004; Klevens, Simon, & Chen, 2012). For example, in neighborhoods where there is low social cohesion, or where residents don't support and trust each other, people are at higher risk for suicide (Desai, Dausey, & Rosenheck, 2005) as well as perpetration of child maltreatment (Coulton, Crampton, Irwin, Spilsbury, & Korbin, 2007; Freisthler, Merritt, & LaScala, 2006), teen dating violence (Capaldi, Knoble, Shortt, & Kim, 2012), intimate partner violence (Pinchevsky & Wright, 2012), and youth violence (Sampson, Morenoff, & Gannon-Rowley, 2002). Additionally, a lack of economic opportunities and unemployment are associated with suicide (Luo, Florence, Quispe-Agnoli, Ouyang, & Crosby, 2011; Reeves et al., 2012), as well as perpetration of child maltreatment (D. Runyan, Wattam, Ikeda, Hassan, & Ramiro, 2002), intimate partner violence (Heise & Garcia-Moreno, 2002; Pinchevsky & Wright, 2012), sexual violence (Centers for Disease Control and Prevention, 2016c) and youth violence (Wilson, 2011). Other shared risk factors for suicide and violence occur at the individual level and include substance abuse, mental health problems, witnessing violence, and a lack of problem-solving skills (Centers for Disease Control and Prevention, 2016a, 2016c, 2016e; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012).

Just as risk factors may be shared across suicide and violence, so too may protective factors overlap. For example, connectedness to one's community (Basile, Hamburger, Swahn, & Choi, 2013; Borowsky,

Hogan, & Ireland, 1997; Centers for Disease Control and Prevention, 2016b; Coulton et al., 2007; Kleiman, Riskind, Schaefer, & Weingarden, 2012; Pinchevsky & Wright, 2012; Widome, Sieving, Harpin, & Hearst, 2008), school (Basile, Espelage, Rivers, McMahon, & Simon, 2009; Capaldi et al., 2012; Carter, McGee, Taylor, & Williams, 2007; DeGue et al., 2013; Hong, Kral, Espelage, & Allen-Meares, 2012; Losel & Farrington, 2012), family (Capaldi et al., 2012; Centers for Disease Control and Prevention, 2016a; Elgar, Craig, Boyce, Morgan, & Vella-Zarb, 2009; Maimon, Browning, & Brooks-Gunn, 2010; Resnick, Ireland, & Borowsky, 2004), caring adults (Capaldi et al., 2012; Losel & Farrington, 2012; Maimon et al., 2010), and pro-social peers (Capaldi et al., 2012; Losel & Farrington, 2012) enhances resilience to suicide and other forms of violence.

The health and economic consequences of suicide are substantial. Suicide and suicide attempts have far-reaching consequences for individuals, families, and communities (Dunne, McIntosh, & Dunne-Maxim, 1987; Mishara, 1995; National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force, 2014; National Action Alliance for Suicide Prevention: Survivors of Suicide Loss Task Force, 2015). In an early study, Crosby and Sacks (2002) estimated that 7% of the U.S. adult population, or 13.2 million adults, knew someone in the prior 12 months who had died by suicide. They also estimated that for each suicide, 425 adults were exposed, or knew about the death. In a more recent study, in one state, Cerel et. al (2016) found that 48% of the weighted survey population knew at least one person who died by suicide in their *lifetimes*. Research indicates that the impact of knowing someone who died by suicide and/or having *lived experience* (i.e. having attempted suicide oneself) is much more extensive than injury and death. People with lived experience may suffer long-term health and mental health consequences ranging from anger, guilt, and physical impairment, depending on the means and severity of the attempt (Chapman & Dixon-Gordon, 2007). Similarly, survivors of a loved one's suicide may experience ongoing pain and suffering including complicated grief (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004), stigma, depression, anxiety, post-traumatic stress disorder, and increased risk of suicidal ideation and suicide (Julie Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014; Sudak, Maxim, & Carpenter, 2008). Less discussed but no less important, are the financial and occupational effects for those left behind (Florence, Simon, Haegerich, Luo, & Zhou, 2015).

The economic toll of suicide is immense as well. According to conservative estimates, in 2013, suicide cost $50.8 billion in estimated lifetime medical and work-loss costs (Florence et al., 2015). By another estimate, the total lifetime costs associated with nonfatal injuries and deaths caused by self-directed violence in 2013 were approximately $93.5 billion after adjusting for under-reporting of suicide (Shepard, Gurewich, Lwin, Reed, & Silverman, 2016). The overwhelming burden of these costs results from lost productivity over the life course, with the average cost per suicide being over $1.3 million (Shepard et al., 2016).

Suicide can be prevented. Despite the myths surrounding suicide, like most public health problems, suicide is preventable (U.S. Public Health Service, 1999). And while progress will continue to be made

into the future, evidence for numerous programs, practices, and policies currently exists, and many programs are ready to be implemented now. Just as suicide is not caused by a single factor, research suggests that suicide will not be prevented by any single intervention taking place in any single setting (Silverman & Maris, 1995; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Rather, suicide prevention is best achieved by a focus across the individual, relationship, family, community, and societal-levels and across all sectors, private and public (e.g., business, public health, physical and behavioral healthcare, justice, education, labor) (National Action Alliance for Suicide Prevention, 2014; World Health Organization, 2014).

Assessing the Evidence

This technical package includes programs, practices, and policies with evidence of impact on suicide or risk or protective factors for suicide. To be considered for inclusion in the technical package, the program, practice, or policy selected had to meet at least one of these criteria: a) meta-analyses or systematic reviews showing impact on suicide; b) evidence from at least one rigorous (e.g., randomized controlled trial [RCT] or quasi-experimental design) evaluation study that found significant preventive effects on suicide; c) meta-analyses or systematic reviews showing impact on risk or protective factors for suicide, or d) evidence from at least one rigorous (e.g., RCT or quasi-experimental design) evaluation study that found significant impacts on risk or protective factors for suicide. Finally, consideration was also given to the likelihood of achieving beneficial effects on multiple forms of violence; no evidence of harmful effects on specific outcomes or with particular subgroups; and feasibility of implementation in a U.S. context if the program, policy, or practice has been evaluated in another country.

Within this technical package, some approaches do not yet have research evidence demonstrating impact on rates of suicide but instead are supported by evidence indicating impacts on risk or protective factors for suicide (e.g., help-seeking, stigma reduction, depression, connectedness). In terms of the strength of the evidence, programs that have demonstrated effects on suicidal behavior (e.g., reductions in deaths, attempts) provide a higher-level of evidence, but the evidence base is not that strong in all areas. For instance, there has been less evaluation of community engagement and family programs on suicidal behavior. Thus, approaches in this package that have effects on risk or protective factors reflect the developing nature of the evidence base and the use of the best available evidence at a given time.

It is also important to note that there is often significant heterogeneity among the programs, policies, or practices that fall within one approach or strategy area in terms of the nature and quality of the available evidence. Not all programs, policies, or practices that utilize the same approach (e.g., gatekeeper training) are equally effective, and even those that are effective may not work across all populations. Tailoring programs and more evaluation may be necessary to address different population groups. The examples provided are not intended to be a comprehensive list of evidence-based programs, policies, or practices for each approach, but rather illustrate models that have been shown to impact suicide or have beneficial effects on risk or protective factors for suicide. In practice, the effectiveness of the programs,

policies and practices identified in this package will be strongly dependent on the quality of their implementation and the communities in which they are implemented. Implementation guidance to assist practitioners, organizations and communities will be developed separately.

Context and Cross-Cutting Themes

The strategies and approaches that have been included in this technical package represent different levels of the social ecology, with efforts intended to impact the community and societal levels, as well individual and relationship levels. The strategies and approaches are intended to work in combination and reinforce each other to prevent suicide (see box below). The strategies are arranged in order such that those strategies hypothesized to have the greatest potential for broad public health impact on suicide are included first, followed by those that might impact more select populations (e.g., persons who have already made a suicide attempt).

Preventing Suicide	
Strategy	**Approach**
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access to mental health care	• Coverage of mental health conditions in health insurance policies
Create protective environments	• Reducing access to lethal means among persons at-risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm approaches • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning • Parenting skill and family relationship approaches
Identify and support people at risk	• Gatekeeper training • Screening combined with care management • Crisis intervention
Intervene to lessen harms and prevent future risk	• Treatment for people at-risk of suicide • Treatment to prevent re-attempts • Postvention • Safe messaging following a suicide

The example programs, policies, and practices have been implemented within particular contexts. The social and cultural context of communities is critically important to take into account when selecting strategies and approaches. Practitioners in the field may be in the best position to assess the needs and strengths of their communities and work with community members to make decisions about the combination of approaches included here that are best suited to their context.

Suicide ideation, attempts, morbidity and mortality vary by gender, race/ethnicity, age, occupation, and other important population characteristics. Barriers to disclosure, help seeking, timely access to quality care, and ongoing support may also vary by population and community characteristics. Ideally, the availability of multiple approaches tailored to the economic, cultural, and environmental context of individuals and communities are desirable as they may increase the likelihood of removing barriers to supportive and effective care and provide opportunities to develop individual and community resilience. These culturally appropriate approaches can then be included in comprehensive strategies to maximize the public health impact on reducing suicide-related morbidity and mortality among individuals and within communities.

This package includes strategies where public health agencies are well positioned to bring leadership and resources to implementation efforts. It also includes strategies where public health can serve as an important collaborator (e.g., strategies addressing community and societal level risks), but where leadership and commitment from other sectors such as business, labor or health care is critical to implement a particular policy or program (e.g., workplace policies; screening combined with care management). The role of various sectors in the implementation of a strategy or approach in preventing suicide is described further in the section on *Sector Involvement*.

In the sections that follow, the strategies and approaches with the best available evidence for preventing suicide are described.

Strengthen Economic Supports

Rationale

Studies from the U.S. examining historical trends indicate that suicide rates increase during economic recessions marked by high unemployment rates, job losses, and economic instability and decrease during economic expansions and periods marked by low unemployment rates, particularly for working-age individuals 25 to 64 years old (Luo et al., 2011; Fowler et al., 2015). Economic and financial strain, such as job loss, long periods of unemployment, reduced income, difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress, can directly increase an individual's risk for suicide or indirectly increase risk by exacerbating related physical and mental health problems; buffering these risks can therefore, potentially protect against suicide (Stack & Wasserman, 2007). For example, strengthening economic support systems can help people stay in their homes or obtain affordable housing while also paying for necessities such as food and medical care, job training, child care, among other expenses required for daily living. In providing this support, stress and anxiety and the potential for a crisis situation may be reduced, thereby preventing suicide.

Approaches

Economic supports for individuals and families can be strengthened by targeting household financial security and ensuring stability in housing during periods of economic stress.

- **Strengthening household financial security** can potentially buffer the risk of suicide by providing individuals with the financial means to lessen the stress and hardship associated with a job loss or other unanticipated financial problems. The provision of unemployment benefits and other forms of temporary assistance, livable wages, medical benefits, and retirement and disability insurance to help cover the cost of necessities or to offset costs in the event of disability, are examples of ways to strengthen household financial security.

- **Housing stabilization policies** aim to keep people in their homes and provide housing options for those in need during times of financial insecurity. This may occur through programs that provide affordable housing such as through government subsidies or through other options available to potential homebuyers such as loan modification programs, move-out planning, or financial counseling services that help minimize the risk or impact of foreclosures and eviction.

Potential Outcomes

- Reductions in suicide rates
- Reductions in foreclosure rates
- Reductions in eviction rates
- Reductions in emotional distress

Evidence

There is evidence suggesting that strengthening household financial security and stabilizing housing can reduce suicide risk.

- **Strengthen household financial security.** An examination of variations in U.S. *unemployment benefit programs* across states demonstrated that the impact of unemployment on suicide was offset in those states that provided greater than average unemployment benefits (Cylus, Glymour, & Avendano, 2014). Another U.S. study examining the link between unemployment and suicide risk using monthly suicide data, length of unemployment, and job losses found that the duration of unemployment, as opposed to just the loss of job, predicted suicide risk (Classen & Dunn, 2012). Together, these results suggest that not only should state unemployment benefit programs be generous in their financial allocations, but also in their duration.

  Other measures to strengthen household financial security (e.g., transfer payments related to retirement and disability insurance, unemployment insurance compensation, medical benefits, and other forms of family assistance) have also shown an impact on suicide. A study by Flavin and Radcliff (2009) examined the impact of states' per capita spending on transfer payments, medical benefits, and family assistance (Temporary Assistance to Needy Families – TANF) and total state spending on suicide rates between 1990-2000, controlling for a number of suicide risk factors (e.g., residential mobility, divorce rate, unemployment rate) at the state level. As per capita spending on total transfer payments, medical benefits, and family assistance increased there was an associated decrease in state suicide rates. Moreover, it wasn't spending in general that was associated with the reduction but spending on these types of assistance. In terms of lives saved, Flavin & Radcliff calculated the cost of reducing a state's suicide rate by a full point for the years studied. At the national level, they estimated that 3,000 fewer suicides would occur per year nationwide if every state increased its per capita spending on these types of assistance by $45 per year (Flavin & Radcliff, 2009). Although this was a correlational study, the results demonstrate the potential benefits of policies that reach particularly vulnerable individuals during periods of great need and increased risk for suicide. More evaluation studies are needed to further understand the outcomes impacted by programs such as these.

- **Housing stabilization policies.** The *National Neighborhood Stabilization Program* was designed to help neighborhoods suffering from high rates of foreclosure and abandonment by slowing the deterioration of the neighborhoods and providing affordable housing options for low, moderate, and middle-income homebuyers. This program also offers financial assistance to eligible individuals for the purchase of a new home. Although this program has not been rigorously evaluated for its impact on suicide outcomes, it addresses foreclosure and eviction, which are

risk factors for suicide. A longitudinal analysis of annual data on suicides and foreclosures demonstrated that as the proportion of foreclosed properties increased in U.S. states, so did the state suicide rate, particularly among working-aged adults (Houle & Light, 2014). Another study of data from 16 U.S. states participating in the National Violent Death Reporting System found that suicides precipitated by home foreclosures and evictions increased more than 100% from 2005 (before the housing crisis began) to 2010 (after it had peaked; Fowler, Gladden, Vagi, Barnes, and Frazier (2015)). Most of these suicides occurred prior to the actual loss of the decedent's home. These findings suggest that integrating suicide prevention resources, messaging, and referrals into financial, foreclosure, and move-out planning and counseling services may help to prevent suicide.

Strengthen Access to Mental Health Care

Rationale

While most people with mental health problems do not attempt or die by suicide (Olfson, Gerhard, Huang, Crystal, & Stroup, 2015; Owens, 2002), and the level of risk conferred by different types of mental illness varies (Arsenault-Lapierre, Kim, & Turecki, 2004; E. C. Harris & Barraclough, 1997; Tyrer, Reed, & Crawford, 2015), previous research indicates that mental illness is an important risk factor for suicide (E. C. Harris & Barraclough, 1998; World Health Organization, 2014). Studies suggest that up to 90% of people who die by suicide may have had a mental illness or substance abuse problems at the time of their deaths (Arsenault-Lapierre et al., 2004; Cavanagh, Carson, Sharpe, & Lawrie, 2003; Isometsa, 2001). State-level suicide rates have also been found to be correlated with general mental health measures such as depression (Lang, 2013; Mark, Shern, Bagalman, & Cao, 2007). Findings from the National Comorbidity Survey indicate that relatively few people in the U.S. with mental health disorders receive treatment for those conditions (Kessler et al., 2005). Lack of access to mental health care is one of the contributing factors related to the underuse of mental health services (Cunningham, 2009). Identifying ways to improve access to timely, affordable, and quality mental health care for people in need is a critical component to suicide prevention (World Health Organization, 2014). Apart from the treatment benefits, it can also serve to normalize help-seeking behavior and increase the use of such services.

Approaches

One approach to strengthening access to mental health care is through the provision of mental health coverage in health insurance policies.

- **Coverage of mental health conditions in health insurance policies.** Federal and state laws include provisions for equal coverage of mental health services in health insurance plans that is on par with coverage for other health concerns (i.e., mental health parity). Benefits and services covered include such things as the number of visits, co-pays, deductibles, inpatient/outpatient services, prescription drugs, and hospitalizations. If a state has a stronger mental health parity law than the federal parity law, then insurance plans regulated by the state must follow the state parity law. If a state has a weaker parity law than the federal parity law (e.g., includes coverage for some mental health conditions but not others), then the federal parity law will replace the state law. Equal coverage does not necessarily imply good coverage as health insurance plans vary in the extent to which benefits and services are offered to address various health conditions. Rather it helps to ensure that mental health services are covered on par with other health concerns.

Potential Outcomes

- Increases in utilization of mental health services

- Reductions in symptoms of mental illnesses
- Reductions in rates of suicide attempts
- Reductions in rates of suicide

Evidence

There is evidence suggesting that coverage of mental health conditions in health insurance policies can reduce risk factors associated with suicide and may directly impact suicide rates.

- **Coverage of mental health conditions in health insurance policies.** The National Survey of Drug Use and Health is a nationally representative survey of the U.S. population that provides data on substance use, mental health conditions, and services utilization. Using data from this survey, K. M. Harris, Carpenter, and Bao (2006) found that 12 months after states enacted *mental health parity laws*, self-reported use of mental healthcare services significantly increased. Moreover, subsequent research by Lang (2013) examined state mental health laws and suicide rates between 1990 and 2004 and found that mental health parity laws, specifically, were associated with an approximate 5% reduction in suicide rates. This reduction, in the 29 states with parity laws, equated to the prevention of 592 suicides per year. Lang et al. (2013) estimated the cost of saving a life through such mandates as mental health parity by comparing the loss in wages attributable to the policy, via increased premiums, to the number of lives saved. Based on these calculations, the cost of saving one life was between $1.3-3.1 million per suicide prevented. However, this calculation did not take into account the saving associated with improved mental health among non-suicidal individuals, increases in productivity, or quality of life associated with increased mental health care. As such, this figure is considered the upper bounds on costs incurred and should be interpreted with caution (Lang, 2013).

Create Protective Environments

Rationale

Prevention efforts that focus not only on individual behavior change (e.g., help-seeking, treatment interventions) but on changes to the environment can increase the likelihood of positive behavioral and health outcomes (Haddon, 1980). Creating environments that address risk and protective factors where individuals live, work, and play, can help prevent suicide (Dahlberg & Krug, 2002; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). For example, rates of suicide and suicide attempts are elevated in certain occupational groups (Han et al., 2016; McIntosh et al., 2016), therefore, changes to the organizational culture in these occupations, by way of implementation of supportive policies or even physical modifications to the workplace environment, can change social norms, encourage help-seeking, and demonstrate that good health and mental health are valued and that stigma and other risk factors for suicide are not (K. L. Knox et al., 2010; National Action Alliance for Suicide Prevention Workplace Task Force, 2015). Similarly, modifying the characteristics of the environment to prevent harmful behavior such as access to lethal means can reduce suicide rates, particularly in times of crisis (Beautrais, Gibb, Fergusson, Horwood, & Larkin, 2009; A.E. Crosby, Espitia-Hardeman, Ortega, & Lozano, 2013; Kaplan et al., 2013; Miller, Warren, Hemenway, & Azrael, 2015; C. W. Runyan et al., 2016).

Approaches

The current evidence suggests three potential approaches for creating environments that protect against suicide.

- **Reducing access to lethal means among persons at-risk of suicide.** Means of suicide such as firearms, hanging/suffocation, or jumping from heights provide little opportunity for rescue and, as such, have high case fatality rates (e.g., about 85% of people who use a firearm in a suicide attempt will die from the injury). Research also indicates that 1) the interval between thinking about and attempting suicide can be as short as 5 or 10 minutes (Deisenhammer et al., 2009; Simon et al., 2001) and 2) that people tend *not* to substitute a different method when a highly lethal method is unavailable or difficult to access (Hawton, 2007; Yip et al., 2012). Therefore, increasing the time interval between the thought and the suicide attempt, for example, by making it more difficult to access lethal means, can be lifesaving. The following are examples of approaches reducing access to lethal means for persons at-risk of suicide:

    - *Intervening at Suicide Hotspots*. Suicide hotspots, or places where suicides may take place relatively easily, include tall structures (e.g., bridges and cliffs), railway tracks, and isolated locations such as parks. Efforts to prevent suicide at these locations include

erecting barriers to prevent jumping and installing signs and telephones to encourage individuals who are considering suicide, to seek help (Cox et al., 2013).

- *Safe Storage Practices.* Safe storage of medications, firearms, and other household products can reduce the risk for suicide by separating individuals who may be vulnerable and/or impulsive from easy access to lethal means. Such practices may include education and counseling around storing firearms--locked in a secure place (e.g., in a gun safe or lock box), unloaded and separate from the ammunition--and keeping medicines in a locked cabinet or other secure location away from people who may be at risk or who have made prior attempts (Rowhani-Rahbar, Simonetti, & Rivara, 2016; C. W. Runyan et al., 2016).

- **Organizational policies and culture** that promote protective environments may be implemented in places of employment. Such policies and cultural values may promote prosocial behavior (e.g., asking for help), skill building, changing social norms, referral and access to helping services (e.g. mental health, substance abuse treatment, financial counseling), and encourage leadership support from the top down. Such policies and cultural shifts can positively impact organizational climate and morale and help prevent suicide and its related risk factors (e.g. depression, social isolation) (National Action Alliance for Suicide Prevention Workplace Task Force, 2015).

- **Community-based policies to reduce excessive alcohol use.** Research studies in the United States have found that greater alcohol availability is positively associated with alcohol-involved suicides (Escobedo & Ortiz, 2002; Giesbrecht et al., 2015). Policies to reduce excessive alcohol use broadly include zoning to limit alcohol outlet locations and density, taxes on alcohol, and bans on the sale of alcohol for individuals under the legal drinking age. These policies are important because acute alcohol use has been found to be associated with more than one-third of suicides and approximately 40% of suicide attempts (Cherpitel, Borges, & Wilcox, 2004).

Potential Outcomes

- Increases in safe storage of means
- Reductions in suicide attempts
- Reductions in suicide deaths
- Increases in help-seeking
- Reductions in alcohol-related suicide deaths

Evidence

The evidence for the effectiveness of preventing suicide by reducing access to lethal means and otherwise establishing protective environments for individuals at risk of suicide is strong, particularly compared to existing evidence for other prevention strategies (Zalsman et al., 2016).

- **Reducing access to lethal means among persons at-risk of suicide.** A meta-analysis examining the impact of *suicide hotspot interventions* implemented in combination or in isolation, both in the U.S. and abroad, found associated reduced rates of suicide (Cox et al., 2013; Pirkis et al., 2015). For example, after erecting a barrier on the Jacques-Cartier bridge in Canada, the suicide rate from jumping from the bridge decreased from about 10 suicide deaths per year to about 3 deaths per year (Perron, Burrows, Fournier, Perron, & Ouellet, 2013). Moreover, the reduction in suicides by jumping was sustained even when all bridges and nearby jumping sites were considered, suggesting little to no displacement of suicides to other jumping sites (Perron et al., 2013). Further evidence for the effectiveness of bridge barriers was demonstrated by a study examining the impact of the *removal* of safety barriers from the Grafton Bridge in Auckland, New Zealand. After removal of the barrier, both the number and rate of suicide increased fivefold (Beautrais, 2001; Beautrais et al., 2009).

  Another form of means reduction involves implementation of *safe storage practices*. In a case-control study of firearm-related events identified from 37 counties in Washington, Oregon, and Missouri, and from 5 trauma centers, Grossman et al. (2005) found that storing firearms unloaded, separate from ammunition, in a locked place or secured with a safety device was protective of suicide attempts among adolescents. Further, a recent systematic review of clinic and community-based education and counseling interventions suggested that the provision of safety devices significantly increased safe firearm storage practices compared to counseling alone or compared to the provision of economic incentives to acquire safety devices on one's own (Rowhani-Rahbar et al., 2016).

  Another program, The *Emergency Department Counseling on Access to Lethal Means (ED CALM)*, trained psychiatric emergency clinicians in a large children's hospital to provide lethal means counseling and safe storage boxes to parents of patients under age 18 receiving care for suicidal behavior. In a pre-post quality improvement project, Runyan et al (2016) found that at post-test 76% (of the 55% of parents followed up, n=114) reported that all medications in the home were locked up as compared to fewer than 10% at the time of the initial emergency department visit. Among parents who indicated the presence of guns in the home at pre-test (i.e. 67%), all (100%) reported guns were currently locked up at post-test (C. W. Runyan et al., 2016).

- **Organizational policies and culture.** *Together for Life* is a workplace program of the Montreal Police Force implemented to address suicide among officers. Policy and program components

were designed to foster an organizational culture that promoted mutual support and solidarity among all members of the Force. The program included training of supervisors, managers and all units to improve competencies in identifying suicidal risk and to improve use and awareness of existing resources. The program also included an education campaign to improve awareness and help-seeking (Mishara & Martin, 2012). Police suicides were tracked over 12 years and compared to rates in the control city of Quebec. The suicide rate in the intervention group decreased significantly by 78.9% to a rate of 6.4 suicides per 100,000 population per year compared to an 11% increase in the control city (29.0 per 100,000) (Mishara & Martin, 2012).

Another example of this approach is the *United States Air Force Suicide Prevention Program (AFSPP).* AFSPP included 11 policy and education initiatives and was designed to change the culture of the Air Force surrounding suicide. The program uses leaders as role models and agents of change, establishes expectations for behavior related to awareness of suicide risk, develops population skills and knowledge (i.e., education and training), and investigates every suicide (i.e., outcomes measurement). The program represents a fundamental shift from viewing suicide and mental illness solely as medical problem and instead sees them as larger service-wide problems impacting the whole community (K. L. Knox, Litts, Talcott, Feig, & Caine, 2003). Using a time-series design to examine the impact of the AFSPP program on various violence-related outcomes, researchers found that the program was associated with a 33% relative risk reduction in suicide (K. L. Knox et al., 2003).The program was also associated with relative risk reductions in related outcomes including moderate and severe family violence (30% and 54%, respectively), homicide (51%), and accidental death (18%) (K. L. Knox et al., 2003). A longitudinal assessment of the program over the period 1981 to 2008 (16 years before the 1997 launch of the program and 11 years post-launch) found significantly lower rates of suicide after the program was launched than before (K. L. Knox et al., 2010). These effects were sustained over time, except in 2004, which the authors found was associated with less rigorous implementation in that year than in the other years (K. L. Knox et al., 2010).

- **Community-based policies to reduce excessive alcohol use.** While multiple policies to limit excessive use of alcohol exist, several studies on alcohol outlet *density*, specifically, suggest that measures to reduce alcohol outlet density can potentially reduce alcohol-involved suicides. Additionally, a longitudinal analysis of alcohol outlet density, suicide mortality, and hospitalizations for suicide attempts over 6 years in 581 California zip codes indicated that the density of bars, specifically, is related to suicide and suicide attempts, particularly in rural areas (Johnson, Gruenewald, & Remer, 2009).

Promote Connectedness

Rationale

Sociologist, Emile Durkheim theorized in 1897 that weak social bonds, i.e. lack of connectedness, are among the chief causes for suicidality (Durkheim, 1897/1951). *Connectedness* is the degree to which an individual or group of individuals are socially close, interrelated, or share resources with others (Centers for Disease Control and Prevention, 2009). Social connections can be formed within and between multiple levels of the social ecology (Dahlberg & Krug, 2002), for instance between individuals (e.g. peers, neighbors, co-workers), families, schools, neighborhoods, workplace, faith communities, cultural groups, and society as a whole. Related to connectedness, *social capital* refers to a sense of trust in one's community and neighborhood, social integration, and also the availability and participation in social organizations (Beyer, Layde, Hamberger, & Laud, 2015; Muennig, Cohen, Palmer, & Zhu, 2013). Many ecological cross-sectional and longitudinal studies have examined the impact of aspects of social capital on depression symptoms, depressive disorder, mental health more generally, and suicide. While the evidence is limited, existing studies suggest the pattern is towards a positive association between social capital measured by social trust, community/ neighborhood engagement, and improved mental health. Connectedness and social capital together can serve to protect against suicidal behaviors by decreasing isolation, encouraging adaptive coping behaviors, increasing belongingness, personal value and worth all of which helps individuals to build resilience in the face of adversity. Connectedness can also provide individuals with better access to formal supports and resources, mobilize communities to meet the needs of its members and provide collective primary prevention activities to the community as a whole (Centers for Disease Control and Prevention, 2009).

Approaches

Promoting connectedness among individuals and within communities through modeling peer norms and enhancing community engagement can protect against suicide.

- **Peer norm approaches** seek to normalize protective factors for suicide such as help-seeking, reaching out and talking to trusted adults, and promote peer connectedness. These approaches typically target youth and are delivered in school settings but can also be implemented in community settings.

- **Community engagement activities**. Community engagement is an aspect of social capital. Community engagement approaches may involve residents participating in a range of activities, including religious activities, community clean-up and greening activities, and physical exercise. These activities provide opportunities for residents to become more involved in the community and to connect with other community members, organizations, and resources, resulting in enhanced overall physical health, reduced stress, and decreased depressive symptoms, thereby reducing risk of suicide.

Potential Outcomes

- Reductions in maladaptive coping attitudes and behaviors
- Increases in healthy coping attitudes and behaviors
- Increases in referrals for youth in distressed
- Increases help-seeking behaviors
- Increases in positive perceptions of adult support

Evidence

Current evidence suggests that peer norm approaches and community engagement can reduce risk factors associated with suicidal behaviors.

- **Peer norm approaches.** Evaluations show that programs such as *Sources of Strength* can improve school norms and beliefs about suicide that are created and disseminated by student peers. In a randomized controlled trial of *Sources of Strength* conducted with 18 high-schools (6 metropolitan, 12 rural), Wyman et al. (2010) found that the program improved adaptive norms regarding suicide among peer leaders, connectedness to adults, and school engagement. Peer leaders were also more likely than controls to refer a suicidal friend to an adult. For students, the program resulted in increased perceptions of adult support for suicidal youths, particularly among those with a history of suicidal ideation, and the acceptability of help-seeking behaviors. Finally, trained peer leaders also reported a greater decrease in maladaptive coping attitudes compared with untrained leaders (Wyman et al., 2010). More evaluation research is needed to examine whether these improvements in factors that protect against suicidal behavior translate into reduced suicidal behavior and suicide.

- **Community engagement activities.** A vacant lot greening initiative was undertaken in Philadelphia between 1999 and 2008. Local residents and community members worked together to green 4,436 lots (or 7.8 million square feet) in 4 areas of the city. Researchers found significant reductions in community residents' self-reported level of stress, which is a risk factor for suicide, and engagement in more physical exercise, a protective factor for suicide, than residents in

control vacant lot areas. Other benefits included reductions in firearm assaults and vandalism (Branas et al., 2011).

Teach Coping and Problem-Solving Skills

Rationale

Building life skills prepares individuals to successfully tackle every day challenges and adapt to stress and adversity. Life skills encompasses many concepts, but most often include coping and problem-solving skills, conflict resolution, and critical thinking. Life skills are important in shielding individuals from suicidal behaviors (World Health Organization, 2014). Suicide prevention programs that focus on life and social skills training are drawn from social cognitive theories (Bandura, 1986), surmising that suicidal behavior is attributed to either direct learning, modeling, or environmental and individual (e.g. hopelessness) characteristics. The literature linking life skills and suicide is robust. The inability to employ adequate strategies to cope with immediate stressors or identify and find solutions for problems has been characterized among suicide attempters (Pollock & Williams, 2004). Treatments that include bolstering skills (Goldsmith, Pellmar, Kleinman, & Bunney, 2002) and include problem-solving techniques (Ghahramanlou-Holloway, Bhar, Brown, Olsen, & Beck, 2012; Townsend et al., 2001) appear to reduce suicidal ideation and attempts more effectively. Prevention programs focused on teaching these skills target youth, parents and families and have been used with both universal and at-risk populations. While many do not target suicidal behaviors directly, these programs strive to train youth and parents in important life skills to offset the underlying vulnerabilities that contribute to engaging in high-risk behaviors early in life.

Approaches

Current evidence provides support for the following two approaches:

- **Social emotional learning programs** focus on developing and strengthening communication and problem-solving skills, emotion regulation, conflict resolution, help seeking and coping skills. These approaches address a range of risk and protective factors for suicidal behavior. They provide children and youth with skills to resolve problems in relationships, school, and with peers, and help youth to address other negative influences (e.g., substance use) associated with suicide. These approaches are typically delivered to all students in a particular grade or school, although some programs also focus on groups of students considered to be at high risk for suicide. Opportunities to practice and reinforce skills are an important part of programs that work (Herman, Borden, Reinke, & Webster-Stratton, 2011).

- **Parenting skill and family relationship programs** are designed to strengthen parenting skills, enhance positive parent-child interactions, and improve children's behavioral and emotional skills and abilities. Several parenting and family relationship programs have been shown in rigorous evaluations to improve resilience and reduce risk factors for various behaviors, including ones closely related to suicide, such as depression, internalizing behaviors, and substance abuse (M. S. Knox, Burkhart, & Hunter, 2010).

Potential Outcomes

- Reductions in suicide attempts and suicide ideation
- Improvements in knowledge of risk and protective factors associated with suicide
- Reductions in suicide risk behaviors (i.e., depression, anxiety, conduct problems, substance abuse)
- Improvements in help-seeking behavior
- Improvements in social competence and emotional regulation skills
- Improvements in problem-solving and conflict management skills

Evidence

There are several programs with evidence that support teaching social, emotional and parenting skills to reduce suicidal behaviors and associated risk factors.

- **Social emotional learning programs.** The *Youth Aware of Mental Health Program (YAM)* is a program developed for teenagers that uses interactive dialogue and role-playing to teach adolescents about the risk and protective factors associated with suicide (including knowledge about depression and anxiety) and enhances their problem-solving skills for dealing with adverse life events, stress, school and other problems. The program includes 3 hours of role-play sessions and interactive workshops combined with a booklet that students can keep, educational posters displayed in classroom, and interactive lectures about mental health at the beginning and end of the program (Wasserman et al., 2014). In a cluster-randomized controlled trial of YAM conducted across 10 European Union countries and 168 schools, students aged 14-16 participating in the YAM program were significantly less likely to attempt suicide and have severe suicidal ideation at the 12-month follow-up compared to the control group which did not participate in an intervention. Overall, the relative risk of youth suicide attempts among the YAM group was reduced by over 50%demonstrating that out of 1000 students, five attempted suicide in the YAM group compared to 11 in the control group. Additionally, related to severe suicide ideation, in the YAM group absolute risk fell by 0.50% and relative risk fell by 49.6% (Wasserman et al., 2014).

Signs of Suicide (SOS) is another school-based prevention program for students aged 13-17. The program includes guided classroom discussions about suicide and depression. As part of the program, students are screened for depression and suicide risk and referred for professional help as indicated. The program is designed to increase knowledge about suicide and risk factors associated with suicidal behavior as well as improve and normalize help-seeking behavior (Schilling, Aseltine, & James, 2016). In a randomized controlled trial, *SOS* was shown to reduce self-reported suicide attempts at 3-months post intervention among participating students compared to control students. The SOS program also increased students' knowledge of how to get help for themselves or friends for depression and/or suicidal thoughts, and favorable attitudes toward help-seeking. SOS participants with a lifetime history of suicide attempt were also less likely to report planning a suicide in the 3 months following the program compared to lower-risk participants (Schilling et al., 2016).

Finally, the *Good Behavior Game (GBG)* is a classroom-based program for elementary school children aged 6-10. The program uses a team-based behavior management strategy that promotes good behavior by setting clear expectations for good behavior and consequences for maladaptive behavior. The goal of the GBG is to create an integrated classroom social system that is supportive of all children being able to learn with little aggressive or disruptive behavior (Wilcox et al., 2008). Two cohorts of youths participated in the program in 1985-85 and 1986-86 school years when they were in the first and second grades. A number of proximal and distal outcomes were assessed among the two cohorts over time. With respect to distal suicide-related outcomes, an outcome evaluation of the *GBG* indicated that individuals in the first cohort who were assigned to participate in *GBG* when they were in the first grade reported half the adjusted odds of suicidal ideation and suicide attempts when assessed approximately 15 years later, between the ages of 19 to 21, compared to peers who had been in a standard classroom setting. The beneficial effect of the program was consistent for suicidal ideation regardless of whether baseline covariates were included. The *GBG* effect on attempts was less robust in some adjusted models including caregiver mental health. In the second cohort of *GBG* students, neither suicidal ideation nor suicide attempts were significantly different between *GBG* and the control interventions (Wilcox et al., 2008). The authors surmise this finding likely arose due to the lack of implementation fidelity and pointed to the need for *GBG* to be delivered with precision, consistency, and teacher support. *GBG* was also found to be associated with reduced risk of later substance abuse, a risk factor for suicide (Kellam et al., 2008).

- **Parenting skill and family relationship programs.** Parenting and family skills training approaches have shown promising impacts in preventing key risk factors associated with suicide. For example, the *Incredible Years (IY)* is a comprehensive group training program for

parents, teachers and children designed to reduce conduct and substance abuse problems, two important suicide risk factors, in youth by improving protective factors such as responsive and positive parent-teacher-child interactions and relationships, emotion self-regulation and social competence (all protective factors for suicide) (Herman et al., 2011). The program includes 9- 20 sessions offered in community-based settings (e.g., religious, recreation centers, mental health treatment centers, and hospitals). Several studies have demonstrated the effect of the *IY* program on reducing internalizing symptoms, such as anxiety and depression, and child conduct problems (C. H. Webster-Stratton, Reid, & Beauchaine, 2011; Webster-Stratton, Jamila Reid, & Stoolmiller, 2008). The program is also associated with improved problem-solving and conflict management; these skills were maintained at 1-year follow-up (Reid, Webster-Stratton, & Hammond, 2003; C. Webster-Stratton & Hammond, 1997; C. Webster-Stratton, Reid, & Hammond, 2001). The program demonstrated greater benefits as the dosage of the intervention increased (Herman et al., 2011).

Additionally, *Strengthening Families 10-14* is a program that involves sessions between parents, youth, and family with the goal of improving parents' skills for disciplining, managing emotions and conflict, and communicating with their children; promoting youths' interpersonal and problem-solving skills; and creating family activities to build cohesion and positive parent-child interactions. The premise of the program is that developing these skills for both parents and children will reduce internalizing behavior and adolescent substance abuse, two important risk factors for suicide (Spoth, Guyll, & Day, 2002). *Strengthening Families* has been shown to significantly decrease externalizing behaviors, such as aggression, alcohol use, and drug use among youth participants, as well as reductions in depression, alcohol use, and drug use among participating families (Spoth et al., 2002).

Identify and Support People At-Risk

Rationale

In order to decrease suicide, attention to people at increased risk, for example people with prior suicide attempts, is necessary, as these individuals tend to experience suicidal behavior at higher than average rates. These vulnerable or disadvantaged populations include, but are not limited to, individuals with lower socio-economic status or who are living with a mental health problem; people who have attempted suicide previously; individuals who are institutionalized, have been victims of violence, or are homeless; and members of certain racial and ethnic minority groups. Supporting these vulnerable groups requires proactive case finding along with access to, and retention in, mental health services. Finding effective ways of identifying at-risk or vulnerable groups, customizing services to make them accessible and engaged in care remain key challenges. For example, simply improving services does not guarantee that those services will be used by those most in need of them, nor will it necessarily increase the number of people who follow treatments that are recommended. People who are disadvantaged face social and economic issues that may adversely affect their ability to respond to the treatments or advice that are offered.

Approaches

The following three approaches focus on identifying and supporting people at increased risk.

- **Gatekeeper training** is designed to train teachers, coaches, providers and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating treatment seeking and support services. Gatekeeper training is typically implemented in schools to identify at-risk youth and within health care settings to identify adults (and youth).

- **Screening combined with care management and overall continuity of care** has been used in primary care and behavioral health care settings to assure that people who may be at high-risk of suicide are identified and receive ongoing treatment as needed, particularly after inpatient discharge and other transitions within the healthcare system so they don't 'slip through the cracks'. These approaches typically employ screening for depression and/or suicide combined with collaborative treatment planning between patients and their providers and patient follow-up.

- **Crisis intervention**. These approaches provide support and referral services, typically by connecting a person in crisis (or a friend or family member of someone at-risk) to trained volunteers or professional staff via telephone hotline, online chat, or text messaging. Crisis intervention approaches are intended to impact key risk factors for suicide, including feelings of

depression, hopelessness, and subsequent mental health care utilization. Like means reduction, crisis interventions can put space or time between an individual who may be considering suicide and harmful behavior.

Potential Outcomes

- Reductions in suicide attempts
- Reductions in suicide deaths
- Increases in identification of individuals at-risk for suicidal behavior
- Increases in at-risk individuals in treatment
- Increases in community members trained to identify at-risk individuals
- Increases in referrals for health care

Evidence

Identifying people at risk of suicide can positively impact both suicide risk factors as well as suicide mortality, however sustained implementation of programs and practices appears critical. Among people who identify *themselves* through calls to suicide hotlines, preliminary evidence finds reductions in suicide risk factors.

- **Gatekeeper training**. One example of gatekeeper training is the *Mental Health First Aid (MHFA)* program. This program is designed for the lay public and consists of three weekly sessions of three hours each. Participants learn the symptoms of people in mental health crises and/or in the early stages of mental health problems (i.e., those experiencing suicidal thoughts and behavior, acute stress reaction, panic attacks and acute psychotic behavior, and depression, anxiety, and psychotic disorders), possible risk factors, and where and how to get effective help (Kitchener & Jorm, 2004). In a randomized controlled trial of 301 participants of *MHFA*, the intervention group, compared to the wait-listed control group, reported at 5 months follow-up, significantly greater feelings of confidence in helping someone (74.5% vs. 57.4%, $p<.001$), greater likelihood of encouraging people to seek professional help (29.4% vs. 16.8%, $p<.007$), improved agreement with health professionals about treatments ($p<.036$), and decreased stigmatizing attitudes towards mental illness ($p<.02$). Additionally, the intervention resulted in improved overall mental health of the participants themselves ($p<.035$). However, the percent who provided some or a lot of help did not differ between groups (Kitchener & Jorm, 2004). Additional research rigorously evaluating *MHFA* for its impact on intervention recipients' suicidal behavior is needed (Kitchener & Jorm, 2006).

Gatekeeper training has also been a primary part of all *Garret Lee Smith (GLS) Suicide Prevention Program* which is in place in 49 states and 48 tribes. A multi-site evaluation assessed the impact of community gatekeeper training on suicide attempts and deaths by comparing the change in suicide rates and nonfatal suicidal behavior among young people aged 10-24 in counties implementing *GLS* trainings, with the trajectory observed in similar counties that did not implement these trainings. Counties that implemented *GLS* trainings had significantly lower youth suicide rates one year following the training implementation (Walrath, Garraza, Reid, Goldston, & McKeon, 2015). This finding equates to a decrease of 1 suicide death per 100,000 among youth ages 10 to 24, or the prevention of approximately 237 deaths in the age group, between 2007 and 2010. Counties implementing *GLS* program activities, including gatekeeper training, also had significantly lower suicide attempt rates among youth ages 16 to 23 in the year following implementation of the *GLS* program than did similar counties that did not implement *GLS* activities (4.9 fewer attempts per 1000 youths; (Godoy Garraza, Walrath, Goldston, Reid, & McKeon, 2015)). More than 79,000 suicide attempts may have been prevented during the period examined, following implementation of the *GLS* program.

- **Screening combined with care management and overall continuity of care.** The *Henry Ford* healthcare system is a large health maintenance organization (HMO) in the state of Michigan. *Henry Ford's Perfect Depression Care* program was the pre-cursor to what is now called *Zero Suicide*, and its overall goal was to eliminate suicide among its members. More broadly, the aim was to redesign delivery of depression care to achieve "breakthrough improvement" in quality and safety by focusing on six aims: effectiveness, safety, patient centeredness, timeliness, efficiency, and equity among patients. The program screened and assessed each patient for suicide risk and implemented coordinated continuous follow-up care system wide (C. E. Coffey, 2006). An examination of the impact of the program found that there was a dramatic and statistically significant decrease in the rate of suicide between the baseline years, 1999 and 2000, prior to the intervention to the intervention years, 2002-2009. During this time period, the suicide rate fell by 82% (C. E. Coffey, 2006; C. E. Coffey, Coffey, & Ahmedani, 2013). Further, among HMO members who received mental health specialty services, the suicide rate decreased from 110.3/100,000 in 1999 to 47.6/100,000 in 2010 ($p<.04$) with a mean of 36.2/100,000 over the time period. Additionally, for those HMO members who accessed only general medical services as opposed to specialty mental health services, the suicide rate increased, from 2.7/100,000 to 5.6/100,000 ($p<.01$). Similarly, in the state of Michigan, rates of suicide in the general population increased over the period from 9.8/100,000 to 12.5/100,000 ($p<.001$) (M. Coffey, Coffey, & Ahmedani, 2015).

- **Crisis intervention.** Suicide prevention hotlines are one way to provide crisis intervention. In an evaluation of the effectiveness of the *National Suicide Prevention Lifeline (NSPL*) to prevent

suicide, 1,085 suicidal individuals who called the hotline completed a standard risk assessment for suicide, and 380 of those completed a follow-up assessment between 1 and 52 days (mean=13.5 days) after the initial assessment. Researchers found that over half of the initial sample were seriously considering suicide when they called, and they had a plan for their suicide. Researchers also found that among follow-up participants, there was a significant decrease in psychological pain ($F=52.8$, $p<.001$), hopelessness ($F=47.8$, $p<.001$) and intent to die ($F=7.57$, $p<.01$) between initiation of the call (time 1) to follow-up (time 3). Between time 2 (end of the call) to time 3, the effect remained for psychological pain ($F=14.1$, $p<.001$) and hopelessness ($F=17.03$, $p<.001$) but was not significant for intent to die. (Gould, Kalafat, Harrismunfakh, & Kleinman, 2007).

In another study, this time employing a randomized controlled trial, Gould, Cross, Pisani, Munfakh, and Kleinman (2013) assessed the impact of the *Applied Suicide Intervention Skills Training (ASIST)*, a widely implemented training program that helps hotline counselors, emergency workers, and other gatekeepers to identify and connect with suicidal individuals, understand their reasoning for living and dying, and assist with safely connecting those in need to available resources. The training was evaluated across the NSPL network of hotlines over the period 2008-2009. Using data from 1,410 suicidal individuals who called 17 Lifeline centers, researchers found that compared to callers who spoke to counselors that received the usual care training, individuals who spoke with counselors without training in *ASIST* were significantly more likely to feel depressed (OR=1.31 (1.01, 1.71)), suicidal (OR=1.74 (1.39, 2.18)), more overwhelmed (OR=1.46 (1.18, 1.82), and less hopeful (1.35 (1.04, 1.77)) by the end of their call to the hotline compared to those with training in *ASIST*. Counselors trained in *ASIST* were also more skilled at keeping callers on the phone longer and establishing a connection with them. However, training in *ASIST* did not result in more comprehensive suicide risk assessments than usual care training (Gould et al., 2013).

Intervene to Lessen Harms and Prevent Future Risk

Rationale

Individuals who have experienced mental health challenges, suicidal ideation, who have made suicide attempts or engaged in non-suicidal self-injury are at increased risk of suicide (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Risk of suicide can also increase among those who have lost a friend, family member, co-worker, or other acquaintance to suicide (Pitman, Osborn, King, & Erlangsen, 2014). Exposure to sensationalized or uninformed reporting regarding on suicide may heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion (Etzersdorfer & Sonneck, 1998; Niederkrotenthaler & Sonneck, 2007).

Approaches

The four approaches included here to lesson harms and reduce future risk of suicide among those at increased risk focus on providing appropriate mental healthcare, continuity of care, caring for the bereaved, and providing safe messaging around suicide.

- **Treatment for people at-risk of suicide** typically includes various forms of psychotherapy delivered by licensed providers to help individuals with mental health problems and other risk factors for suicide with problem-solving, impulsivity and emotion regulation. Treatment usually takes place in a one on one or group format between patients and clinicians in mental healthcare settings and can vary in duration from several weeks to ongoing therapy for years in some cases.

- **Treatment to prevent re-attempts.** These approaches typically include follow-up contact and use diverse modalities (e.g., home visits, mail, telephone, e-mail) to engage recent suicide attempt survivors in continued treatment to prevent re-attempts. Treatment may focus on improved coping skills, mindfulness, and other emotional regulation skills, and may include case management home visits to increase adherence to treatment and continuity of care; and one-on-one interpersonal therapy and/or group therapy. Approaches that engage and connect attempters to peers and providers are especially important because many attempters do not present to aftercare; 12%-25% reattempt within a year, and 3%-9% of attempt survivors die by suicide within 1 to 5 years of their initial attempt (Inagaki et al., 2015)

- **Postvention** approaches are implemented *after* a suicide has taken place and may include debriefing sessions, counseling, and/or bereavement support groups for surviving friends and family members/loved ones. These programs have not typically been evaluated for their impact on suicide or suicidal behavior but may reduce survivors' guilt, feelings of depression, and complicated grief (Szumilas & Kutcher, 2011).

- **Safe messaging following a suicide.** The manner in which information on a recent suicide is communicated to the public (e.g. school assemblies, mass media, social media) can heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion. Therefore, responsible and safe reporting may help prevent suicide and suicide contagion.

Potential Outcomes

- Reductions in mental health-related sequelae
- Increases in connectedness
- Improvements in coping skills
- Improvements in messaging following suicide
- Reductions in re-attempts
- Reductions in contagion effects related to suicide

Evidence

The evidence addressing strategies to lesson harm and prevent future risk of suicide includes the evaluation of effects of specific approaches on risk and protective factors as well as suicide-related mortality. However, because the evaluation of suicide-related mortality requires large sample sizes and extended follow-up, much of the evidence in this area primarily focuses on risk and protective factors.

- **Treatment for people at-risk of suicide**. There are a number of treatments with evidence of impact on risk and protective factors for suicide. One example is the *Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)* program. *IMPACT* aims to prevent suicide among older primary care patients by reducing suicide ideation and depression in primary care settings. It facilitates the development of a therapeutic alliance, a personalized treatment plan that includes patient preferences, as well as proactive follow-up (biweekly during an acute phase and monthly during continuation phase) by a depression care manager (Hunkeler et al., 2006). The program has been shown to significantly improve quality of life, and to reduce functional impairment, depression and suicidal ideation over 24-months of follow-up (Hunkeler et al., 2006; Unutzer et al., 2006) relative to patients who received care as usual.

  Another example is *Collaborative Assessment and Management of Suicidality (CAMS)*, which is a therapeutic approach for suicide-specific assessment and treatment of patient's suicide risk. This flexible approach can be used across treatment settings and clinician theoretical orientations and involves the clinician and patient working together in an interactive assessment process to

develop patient-specific treatment plans. *CAMS* sessions are collaborative and involve constant patient input about what is and is not working with the ultimate goal of enhancing the therapeutic alliance and increasing treatment motivation in the suicidal patient. *CAMS* been tested and supported in 6 correlational studies (Jobes, 2012), in a variety of inpatient and outpatient settings and in one RCT with several additional RCTs under way. *CAMS* has been associated with significant improvements in suicidal ideation, overall symptom distress, and feelings of hopelessness at 12 month follow-up among a community-based sample of suicidal outpatients. (Comtois et al., 2011).

Other examples include *Dialectical Behavioral Therapy (DBT)* and *Attachment-Based Family Therapy (ABFT). DBT* is a multicomponent therapy for individuals at high risk for suicide and who may struggle with impulsivity and emotional regulation. The components of *DBT* include individual therapy, group skills training, between-session telephone coaching and a therapist consultation team. In a randomized controlled trial of women with recent suicidal or self-injurious behavior, those receiving *DBT* were half as likely to make a suicide attempt at two-year follow-up than women receiving community treatment (23% vs 46%), required less hospitalization for suicide ideation, and had lower medical risk across all suicide attempts and self-injurious acts combined (Linehan et al., 2006).

ABFT is a program for adolescents aged 12-18 and is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety (Diamond et al., 2010). A randomized controlled trial of ABFT found that suicidal adolescents assigned to *ABFT* experienced significantly greater improvement in suicidal ideation over 24 weeks of follow-up than did adolescents assigned to enhanced usual care. Additionally, a significantly higher percentage of *ABFT* participants reported no suicidal ideation in the week prior to assessment at 12 weeks than did adolescents receiving enhanced usual care (69.2% vs. 34.6%) and at 24 weeks (82.1% vs. 46.2%) (Diamond et al., 2010).

- **Treatment to prevent re-attempts.** Several strategies that aim to prevent re-attempts have demonstrated impact on reducing suicidal behavior. For example, *Emergency Department Brief Intervention with Follow-up Visits* is a program that involves a one-hour discharge information session that addresses suicidal behavior, distress, risk and protective factors, alternatives to suicidal behavior, and referral options, combined with nine follow-up contacts over 18 months (at 1, 2, 4, 7, 11 weeks and 4, 6, 12, 18 months). Follow-up contacts are either conducted by phone or through home visits according to a specific time line for up to 18-months. A randomized controlled trial that enrolled suicide attempters from eight hospital emergency departments in five culturally different countries (Brazil, India, Sri Lanka, Iran, and China) found that a brief intervention combined with 9 follow-up visits over 18-months was associated with significantly

fewer deaths from suicide relative to a treatment-as-usual group (0.2% versus 2.2%, respectively) (Fleischmann et al., 2008).

Another example of treatment to prevent re-attempts involves *active follow-up contact approaches* such as postcards, letters, and telephone calls intended to increase a patient's sense of connectedness with health care providers and decrease isolation. These approaches include expression of care and support and typically invite patients to reconnect with their provider. Contacts are made periodically (e.g., monthly or every few months in the first 12 months post-discharge with some programs continuing contact for two or more years). In a meta-analysis conducted by Inagaki et al. (2015), interventions to prevent repeat suicidal behavior in patients admitted to an emergency department for suicide attempt were found to reduce reattempts by approximately 17% for up to 12 months post-discharge; however, the effects of these approaches over periods of time longer than one year on reattempts has not yet been demonstrated. Also, because the number of trials and associated sample sizes included in this meta-analysis were small, it was not possible to determine the effect of active contact and follow-up approaches on death by suicide. In a randomized controlled trial of the post-crisis suicide prevention long-term follow-up contact approach, Motto and Bostrom (2001) found that patients who refused ongoing care but who were randomized to be contacted by letter four times per year had a lower rate of suicide over two years of follow-up than did patients in the control group who received no further contact. Other studies have also shown post-crisis letters and coping cards to be protective against suicide ideation and attempts (Hassanian-Moghaddam, Sarjami, Kolahi, & Carter, 2011; Wang et al., 2016).

Finally, *Cognitive Behavior Therapy for Suicide Prevention (CBT-SP*) is an example of a therapeutic approach to prevent re-attempts. It uses a risk-reduction, relapse prevention approach that includes an analysis of proximal risk factors and stressors (e.g., relationship problems, school or work-related difficulties) leading up to and following the suicidal event; safety plan development; skill building; and psychoeducation. *CBT-SP* also has family skill modules focused on family support and communication patterns as well as improving the family's problem solving skills. A randomized controlled trial of *CBT-SP* found that 10-session outpatient cognitive therapy designed to prevent repeat suicide attempts resulted in a 50% reduction in the likelihood of a suicide reattempt among adults who had been admitted to an emergency department for a suicide attempt relative to treatment as usual (Brown et al., 2005).

- **Postvention** programs are implemented with the goal of providing support to survivors of others' suicide to reduce their own risk of suicide. One example of a postvention program, *StandBy Response Service* (*StandBy),* provides clients with face-to-face outreach and telephone support through a professional crisis response team. Site coordinators develop customized case

management plans, referring clients to other existing community services matched to their needs (Visser, Comans, & Scuffham, 2014). In a study by Visser et al. (2014), *StandBy* clients were significantly less likely to be at high risk for suicidality than a suicide bereaved comparison group who had not had contact with the *StandBy* program (48% and 64% respectively). Additionally, research suggests that active postvention approaches in which outreach to suicide survivors occurs at the scene of a suicide is associated with intake into treatment sooner, greater attendance at support group meetings, and attendance at more meetings compared to passive postvention (versus passive approaches where survivors self-refer for services) (J. Cerel & Campbell, 2008).

- **Safe messaging following a suicide.** Safe messaging after a suicide can help assure that reporting of the event is done in such a way to reduce risk to consumers of news media and other messaging who may be particularly vulnerable. One way to ensure safe messaging following a suicide is to encourage that reporters adhere to *Recommendations for Reporting on Suicide* (http://www.reportingonsuicide.org). Reports that are both inclusive of suicide prevention messages, stories of hope and resilience, risk and protective factors, and links to helping resources (e.g., hotline) and that avoid sensationalizing events or reducing suicide to one cause can help reduce the likelihood of suicide contagion. The most compelling evidence supporting the effect of *recommendations* for reporting on suicide on reduction in suicides comes from Austria. After a sharp increase in suicides on the Viennese subway, media guidelines were introduced and an interrupted time series design was used to evaluate the national impact of the guidelines on subsequent suicides. Changes in the quality and quantity of media reporting resulted in a nationwide significant reduction of 81 suicides annually (Niederkrotenthaler & Sonneck, 2007). Finally, research suggests that not only does reporting on suicide in a negative way (e.g., reporting on suicide myths and repetition) have harmful effects on suicide, but reporting on positive coping skills in the face of adversity can also demonstrate protective effects against suicide (Niederkrotenthaler et al., 2010). Reports of individual suicidal ideation not accompanied by reports of suicide or suicide attempts, along with reports describing a "mastery" of a crisis situation where adversities were overcome, associated with significant decreases in suicide rates in the time period immediately following such reports (Niederkrotenthaler et al., 2010).

Sector Involvement

Public health can play an important and unique role in addressing suicide. Public health agencies, which typically place prevention at the forefront of efforts and work to create broad population-level impact, can bring critical leadership and resources to bear on this problem. For example, these agencies can serve as a convener, bringing together partners and stakeholders to plan, prioritize, and coordinate suicide prevention efforts. Public health agencies are also well positioned to collect and disseminate data, implement preventive measures, evaluate programs, and track progress. Although public health can play a leadership role in preventing suicide, the strategies and approaches outlined in this technical package cannot be accomplished by the public health sector alone. As noted in the National Strategy to Prevent Suicide, the integration and coordination of prevention activities across sectors and settings is critical for expanding the reach and impact of suicide prevention efforts.

Other sectors vital to implementing this package include, but are not limited to, education, government (local, state, and federal), social services, health services, business, labor, justice, housing, media, and organizations that comprise the civil society sector such as faith-based organizations, youth-serving organizations, foundations, and other non-governmental organizations. Collectively, these sectors can make a difference in preventing suicide by impacting the various contexts and underlying risks that contribute to suicide.

The strategies and approaches described in this technical package are summarized in Appendix A along with the relevant sectors that are well positioned to lead implementation efforts. For example, business and labor, health care insurers and providers, and government entities are in the best position to implement programs and policies that *Strengthen Economic Supports* and *Access to Mental Health Care*. These types of supports go beyond individual behavior change and require commitment and support from those sectors that can directly address some of the underlying risks and the environmental contexts that increase the risk for suicide. Public health entities can play an important role by gathering and synthesizing information to inform policy, raise awareness, and evaluate the effectiveness of various policies. Moreover, partnerships with non-governmental and community organizations can be instrumental in increasing awareness of and garnering support for policies affecting individuals and families.

The public health sector has been at the forefront of many community-based prevention efforts, working collaboratively with schools and community-based organizations, to change social norms and positively impact health behavior. Public health is well suited to take on a similar leadership role in *Promoting Connectedness* through peer norm and community engagement activities and supporting the development, evaluation, and adoption of effective programs that *Teach Coping and Problem-Solving Skills* to prevent suicide from happening in the first place. These programs are often delivered in school and community settings, making education and non-governmental organizations vital partners in prevention.

Businesses, workplaces, and local and state government entities, on the other hand, are in the best position to establish policies and support practices that *Create Protective Environments* where people live, work, and play. Public health entities can play an important role by gathering and synthesizing information, working with other agencies within the executive branch of their state or local government in support of policy and other approaches, and evaluating the effectiveness of measures taken. In a similar fashion, public health entities can partner with schools, workplaces, and community organizations to implement and evaluate prevention programs, policies and practices geared toward creating safe, healthy, and supportive environments.

Finally, this technical package includes a number of interventions delivered in hospital, primary care, behavioral health care, and community settings designed to *Identify and Support People At-Risk* and to *Lessen Harms and Prevent Future Risk*. The intensity and activities of these interventions require the expertise of professionals who are licensed and trained to deliver critical intervention support. The health care, social services, and justice sectors can work collaboratively to support individuals at high-risk for suicide and their families. These activities also require coordination of supports across various service providers and community organizations.

Regardless of strategy, action by many sectors will be necessary for the successful implementation of this package. In this regard, all sectors can play an important and influential role in preventing suicide from happening in the first place and lessening the immediate and long-term harms of suicidal behavior by helping those in times of crisis get the services and support they need.

Monitoring and Evaluation

Monitoring and evaluation are necessary components of the public health approach to prevention. It is important to have timely and reliable data to monitor the extent of the problem and to evaluate the impact of prevention efforts. Data are necessary for program implementation as planning, implementation, and assessment all rely on accurate measurement of the problem.

Surveillance data helps researchers and practitioners track changes in the burden of suicide. Surveillance systems exist at the federal, state, and local levels. It is important to assess the availability of surveillance data and data systems across these levels to identify and address gaps in the systems. CDC's National Vital Statistics System and the National Violent Death Reporting System (NVDRS) are examples of surveillance systems that provide data on deaths from suicide. NVDRS, for example, is a state-based surveillance system that combines data from death certificates, law enforcement reports, and coroner or medical examiner reports to provide detailed information on the circumstances of violent deaths, including suicide, which can assist communities in guiding prevention approaches (Blair, Fowler, Jack, & Crosby, 2016). The National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP) provides nationally representative data about all types and causes of nonfatal injuries treated in U.S. hospital emergency departments, and can be used to assess national rates of, and trends in, self-harm injuries by cause (e.g., falls, poisoning, etc.), age, race/ethnicity, sex, disposition (where the injured person goes when released from the Emergency Department).

In addition to information on deaths and nonfatal injuries, there are also surveillance systems that provide national, state, and some local estimates of suicidal behavior. The Youth Risk Behavior Surveillance System (YRBSS) collects information from a nationally representative sample of 9-12 grade students and is a key resource in monitoring health-risk behaviors among youth, including whether youth have seriously considered attempting suicide, attempted suicide, made a plan, or required treatment by a doctor or nurse for a suicide attempt that resulted in an injury, poisoning, or overdose (Brener et al., 2013). The YRBSS data are obtained from a national school-based survey conducted by CDC as well as from state, territorial, tribal, and large urban school district surveys conducted by education and health agencies. The National Survey on Drug Use and Health (NSDUH) is an annual survey of the civilian, non-institutionalized population aged 12 years and older. NSDUH provides both national and state-level estimates of substance use, including alcohol, tobacco, illicit drugs, and non-medical use of prescription drugs; and mental health, including past year mental illness, co-occurring illnesses, service utilization, along with suicide ideation, suicide plans, and suicide attempts. NSDUH is a key resource to track trends in suicide-related risk factors in the population and to help identify groups at increased risk.

It is also important at all levels (local, state, and federal) to address gaps in responses, track progress of prevention efforts and evaluate the impact of those efforts, including the impact of this technical package. Evaluation data, produced through program implementation and monitoring, is essential to provide information on what does and does not work to reduce rates of suicide and its associated risk

and protective factors. Theories of change and logic models that identify short, intermediate, and long-term outcomes are an important part of program evaluation.

The evidence-base for suicide prevention has advanced greatly over the last few decades. However, additional research is needed to understand the impact of programs, policies, and practices on suicide (and suicide attempts, at a minimum), as opposed to merely examining their effectiveness on risk factors. More research is also needed to examine the effectiveness of upstream (before risk occurs) and community-level strategies to prevent suicide at the population level. Lastly, it will be important for researchers to test the effectiveness of combinations of the strategies and approaches included in this package. Most existing evaluations focus on approaches implemented in isolation, but there is potential to understand the synergistic effects within a comprehensive prevention approach.

Conclusion

Suicide is a serious public health problem whose rates have been on the rise for more than a decade and whose costs stretch well into the billions of dollars each year. While suicide is a rare outcome statistically, its human impact has a ripple effect that is far-reaching. Each of us likely interacts with suicide survivors, those with lived experience, and those with thoughts of suicide, on a daily basis--at home, at work, and in our communities. Suicide and suicide attempts are therefore public health issues of societal concern. Fortunately, like many public health problems, suicide is preventable, and fortunately more is being done to prevent suicide than ever before, as evidenced by the work of the National Action Alliance for Suicide Prevention, the release of the first world report on suicide, and more timely surveillance data, to name just a few examples. Unfortunately and unlike most other public health problems, suicide prevention must still overcome the: stigma, shame, and secrecy related to help-seeking, mental illness, being a survivor, or someone with lived experience; misplaced fear related to asking someone about their risk of suicide (versus the fear and consequence of *not* asking), fear of taking up strategies known to be effective but perhaps unpopular; misinformation about suicide preventability, misplaced emphasis by the media and others on sensational aspects of suicide, and disproportionate funding given its public health burden.

In an effort to continue pushing the field and society further towards prevention, this technical package includes strategies and approaches that ideally would be used in a comprehensive fashion, in combination--in a multi-level, multi-sectoral way. This technical package includes strategies and approaches targeting upstream prevention (e.g., social emotional learning for children and youth), as well as strategies focused more downstream (e.g., cognitive behavioral treatment to prevent re-attempts). It includes strategies that range from a focus on the whole population regardless of risk to strategies designed to support people at highest risk. Importantly, this technical package extends the bounds of the typical prevention strategies to consider approaches that go beyond individual behavior

change to better address risk factors impacting communities and populations more broadly e.g., policies to stabilize housing and community engagement initiatives.

While the evidence base continues to emerge, the collection of programs, policies, and practices laid out here are available for implementation now. And in keeping with good public health practice, the intent is that monitoring and evaluation will play a key role in that implementation. Moreover, as new evidence becomes available, this technical package can be refined to reflect the current state of the science.

In closing, and in keeping with a message of resilience as spoken by those with lived experience, 'hope, help, and healing is possible.'

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Appendix A: Summary of Strategies and Approaches to Prevent Suicide

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		Suicide	Suicide Attempts or Ideation	Other Risk/Protective Factors for Suicide	
Strengthen economic supports	**Strengthen household financial security**				Government (local, state, Federal) Business/labor
	Unemployment benefit programs	✓			
	Other income supports	✓			
	Housing stabilization policies				Government (local, state, Federal)
	The National Neighborhood Stabilization Program			✓	
Strengthen access to mental health care	**Coverage of mental health conditions in health insurance policies**				Health care Government (state, Federal)
	Mental Health Parity Laws	✓		✓	
Establish protective environments	**Reducing access to lethal means among persons at-risk**				Government (local, state) Public Health
	Intervening at suicide hot spots	✓			
	Safe storage practices		✓	✓	
	Organizational policies and culture				Business/Labor Government (local, state, Federal)
	Together for Life	✓			
	US Air Force Suicide Prevention Program	✓		✓	

		Best Available Evidence			
	Community-based policies to reduce excessive alcohol use				Government (local, state) Business/labor
	Alcohol outlet density	✓		✓	
Promote connectedness	**Peer norm approaches**				Public Health Education
	Sources of Strength			✓	
	Community-engagement activities				Public Health Government (local)
	Greening vacant urban spaces			✓	
Teach coping and problem-solving skills	**Social emotional learning**				Public Health Education
	Youth Aware of Mental Health Program		✓		
	Signs of Suicide		✓	✓	
	Good Behavior Game		✓	✓	
	Parenting skill and family relationship approaches				Public Health Education
	The Incredible Years			✓	
	Strengthening Families 10-14			✓	
Identify and	**Gatekeeper training**				Public Health Healthcare
	Mental Health First Aid			✓	
	Screening combined with care management				Healthcare

		Best Available Evidence			
support people at-risk	*Henry Ford Perfect Depression Care (Precursor to Zero Suicide)*	✓		✓	Social Services
	Crisis Intervention				Public Health
	National Suicide Prevention Lifeline		✓	✓	Social Services
	Applied Suicide Intervention Skills Training		✓	✓	
Intervene to lessen harms and prevent future risk	**Treatment for people at risk of suicide**				Healthcare
	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)		✓	✓	Social Services Justice
	Collaborative Assessment and Management of Suicidality (CAMS)		✓	✓	
	Dialectical Behavioral Therapy		✓	✓	
	Attachment-Based Family Therapy		✓		
	Treatment to prevent re-attempts				Healthcare
	ED Brief Intervention with Follow-up Visits	✓			Social Services
	Active follow-up contact approaches	✓	✓		
	CBT for Suicide Prevention				
	Postvention				Healthcare

		Best Available Evidence			
	StandBy Response Service		✓		
	Safe messaging following a suicide				Public Health Media
	Media Guidelines	✓			

[1]This column refers to the lead sectors well positioned to bring leadership and resources to implementation efforts. For each strategy, there are many other sectors such as non-governmental organizations that are instrumental to prevention planning and implementing the specific programmatic activities.

Preventing Suicide:
A Technical Package of Policy, Programs, and Practices

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Overview

This technical package represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide. These strategies include strengthening economic supports; strengthening access to mental health care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at-risk; and intervening to lessen harms and prevent future risk. The strategies represented in this package include those with a focus on preventing suicide from happening in the first place as well as approaches to lessen the immediate and long-term harms of suicidal behavior for individuals, families, communities, and society. The strategies in the technical package support the goals and objectives of the National Strategy for Suicide Prevention and the National Action Alliance for Suicide Prevention's priority to strengthen community-based prevention. Commitment, cooperation, and leadership from numerous sectors, including public health, education, justice, health care, social services, business, labor, and government can bring about the successful implementation of this package.

What is a Technical Package?

A technical package is a compilation of a core set of strategies to achieve and sustain substantial reductions in a specific risk factor or outcome (Frieden, 2014). Technical packages help communities and states prioritize prevention activities based on the best available evidence. This technical package has three components. The first component is the ***strategy*** or the preventive direction or actions to achieve the goal of preventing suicide. The second component is the ***approach***. The approach includes the specific ways to advance the strategy. This can be accomplished through *programs, policies, and practices*. The approaches included come primarily from studies based in the United States. The ***evidence*** for each of the approaches in preventing suicide or its associated risk factors is included as the third component. This package is intended as a resource to guide and inform prevention decision-making in communities and states.

Preventing Suicide is a Priority

Suicide, as defined by the Centers for Disease Control and Prevention (CDC), is part of a broader class of behavior called *self-directed violence*. Self-directed violence refers to behavior directed at oneself that deliberately results in injury or the *potential* for injury (A.E. Crosby, Ortega, & Melanson, 2011). Self-directed violence may be *suicidal* or *non-suicidal* in nature. For the purposes of this document, we refer only to behavior where suicide is intended:

- **Suicide** is a death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

- **Suicide attempt** is defined as a *non-fatal* self-directed and potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicide is highly prevalent. Suicide presents a major challenge to public health in the United States and worldwide. It contributes to premature death, morbidity, lost productivity, and health care costs (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014). In 2014 (the most recent year of available death data), suicide was responsible for 42,773 deaths in the U.S., which is approximately one suicide every 12 minutes (Centers for Disease Control and Prevention, 2016d). In 2014, suicide ranked as the 10th leading cause of death and has been among the top 12 leading causes of death since 1975 in the U.S (Centers for Disease Control and Prevention, 2016d). Overall suicide rates have increased 24% from 1999 to 2014 (Curtin, Warner, & Hedegaard, 2016). Suicide is a problem throughout the life span; it is the second leading cause of death among those aged 10–34 years; it is the fourth leading cause among persons in their 40s and seventh among persons in their 50s. Suicide rates vary by race/ethnicity with the highest rates, across the lifespan, occurring among non-Hispanic American Indian/Alaska Native (AI/AN) (rate: 17.8/100,000). Among AI/AN, young people are disproportionately at increased risk of suicide with young males aged 25-29 experiencing the highest rates (rate: 56.9/100,000). Moreover, suicide rates among non-Hispanic AI/AN have increased by 48.7% since 1999 (Centers for Disease Control and Prevention, 2016d).

Suicides reflect only a portion of the problem (A.E. Crosby, Han, Ortega, Parks, & Gfroerer, 2011). Substantially more people are hospitalized as a result of nonfatal suicidal behavior (i.e. suicide attempts) than are fatally injured, and an even greater number are either treated in ambulatory settings (e.g., emergency departments) or not treated at all (A.E. Crosby, Han, et al., 2011). For example, during 2014, among adults aged 18 years and older, for every one suicide there were 9 adults treated in hospital emergency departments for self-harm injuries, 27 who reported making a suicide attempt, and over 227 who reported seriously considering suicide (i.e. ideation) (Ferdon et al., In press).

Suicide is associated with several risk and protective factors. Suicide, like other human behaviors, has no single determining cause. Instead, suicide occurs in response to multiple biological, psychological, interpersonal, environmental and societal influences that interact with one another, often over time. The social-ecological model-- encompassing multiple levels of focus from the individual, relationship, community, and societal-- is a useful framework for viewing and understanding suicide risk factors identified in the literature (Dahlberg & Krug, 2002). Risk and protective factors for suicide exist at each level. For example, risk factors include:

- **Individual level**: History of depression and other mental illnesses, hopelessness, substance abuse, certain health conditions, previous suicide attempt, violence victimization and perpetration, and genetic and biological determinants
- **Relationship level**: High conflict or violent relationships, sense of isolation and lack of social support, family/loved one's history of suicide, financial and work stress

- **Community level**: Inadequate community connectedness, barriers to health care (e.g., lack of access to providers and medications)
- **Societal level**: Availability of lethal means of suicide, unsafe media portrayals of suicide, stigma associated with help-seeking and mental illness (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014).

It is important to recognize that the vast majority of individuals who are depressed or who have other risk factors noted, do *not* die by suicide. Furthermore, the relevance of each risk factor can vary by age, race, gender, sexual orientation, residential geography, and socio-cultural and economic status (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014).

Protective factors, or those influences that guard *against* the risk for suicide, can also be found across the different levels of the social-ecological model. Protective factors identified in the literature include: effective coping and problem solving skills, moral objections to suicide, strong and supportive relationships with partners, friends, and family; connectedness to school, community and other social institutions; availability of quality and ongoing physical and mental health care, and reduced access to lethal means (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012; World Health Organization, 2014). These protective factors can either counter a specific risk factor or guard against a number of risks associated with suicide.

Suicide is connected to other forms of violence. Suicide and other forms of violence often share some of the same root causes (Butchart, Phinney, Check, & Villaveces, 2004; Klevens, Simon, & Chen, 2012). For example, in neighborhoods where there is low social cohesion, or where residents don't support and trust each other, people are at higher risk for suicide (Desai, Dausey, & Rosenheck, 2005) as well as perpetration of child maltreatment (Coulton, Crampton, Irwin, Spilsbury, & Korbin, 2007; Freisthler, Merritt, & LaScala, 2006), teen dating violence (Capaldi, Knoble, Shortt, & Kim, 2012), intimate partner violence (Pinchevsky & Wright, 2012), and youth violence (Sampson, Morenoff, & Gannon-Rowley, 2002). Additionally, a lack of economic opportunities and unemployment are associated with suicide (Luo, Florence, Quispe-Agnoli, Ouyang, & Crosby, 2011; Reeves et al., 2012), as well as perpetration of child maltreatment (D. Runyan, Wattam, Ikeda, Hassan, & Ramiro, 2002), intimate partner violence (Heise & Garcia-Moreno, 2002; Pinchevsky & Wright, 2012), sexual violence (Centers for Disease Control and Prevention, 2016c) and youth violence (Wilson, 2011). Other shared risk factors for suicide and violence occur at the individual level and include substance abuse, mental health problems, witnessing violence, and a lack of problem-solving skills (Centers for Disease Control and Prevention, 2016a, 2016c, 2016e; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012).

Just as risk factors may be shared across suicide and violence, so too may protective factors overlap. For example, ~~connectedness increases individual's and communities' resilience to suicide and other forms~~

~~of violence, including~~ connectedness to one's community (Basile, Hamburger, Swahn, & Choi, 2013; Borowsky, Hogan, & Ireland, 1997; Centers for Disease Control and Prevention, 2016b; Coulton et al., 2007; Kleiman, Riskind, Schaefer, & Weingarden, 2012; Pinchevsky & Wright, 2012; Widome, Sieving, Harpin, & Hearst, 2008), school (Basile, Espelage, Rivers, McMahon, & Simon, 2009; Capaldi et al., 2012; Carter, McGee, Taylor, & Williams, 2007; DeGue et al., 2013; Hong, Kral, Espelage, & Allen-Meares, 2012; Losel & Farrington, 2012), family (Capaldi et al., 2012; Centers for Disease Control and Prevention, 2016a; Elgar, Craig, Boyce, Morgan, & Vella-Zarb, 2009; Maimon, Browning, & Brooks-Gunn, 2010; Resnick, Ireland, & Borowsky, 2004), caring adults (Capaldi et al., 2012; Losel & Farrington, 2012; Maimon et al., 2010), and pro-social peers (Capaldi et al., 2012; Losel & Farrington, 2012) enhances resilience to suicide and other forms of violence.

The health and economic consequences of suicide are substantial. Suicide and suicide attempts have far-reaching consequences for individuals, families, and communities (Dunne, McIntosh, & Dunne-Maxim, 1987; Mishara, 1995; National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force, 2014; National Action Alliance for Suicide Prevention: Survivors of Suicide Loss Task Force, 2015). ~~By one conservative estimate, for every death by suicide six people are directly impacted (i.e. survivors). Based on this figure it is estimated that there are over 13 million survivors in the U.S. and unfortunately, survivorship itself is a risk factor for suicide (Crosby & Sacks, 2002). Research indicates that the health consequences of suicide, are also much more extensive than injury and death.~~ In an early study, Crosby and Sacks (2002) estimated that 7% of the U.S. adult population, or 13.2 million adults, knew someone in the prior 12 months who had died by suicide. They also estimated that for each suicide, 425 adults were exposed, or knew about the death. In a more recent study, in one state, Cerel et. al (2016) found that 48% of the weighted survey population knew at least one person who died by suicide in their *lifetimes*. Research indicates that the impact of knowing someone who died by suicide and/or having *lived experience* (i.e. having attempted suicide oneself) is much more extensive than injury and death. People with lived experience may suffer long-term health and mental health consequences ranging from anger, guilt, and physical impairment, depending on the means and severity of the attempt (Chapman & Dixon-Gordon, 2007). Similarly, survivors of a loved one's suicide may experience ongoing pain and suffering including complicated grief (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004), stigma, depression, anxiety, post-traumatic stress disorder, and increased risk of suicidal ideation and suicide (Julie Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014; Sudak, Maxim, & Carpenter, 2008). Less discussed but no less important, are the financial and occupational effects for those left behind (Florence, Simon, Haegerich, Luo, & Zhou, 2015).

The economic toll of suicide is immense as well. According to conservative estimates, in 2013, suicide cost $50.8 billion in estimated lifetime medical and work-loss costs (Florence et al., 2015). By another estimate, ~~t~~The total lifetime costs associated with nonfatal injuries and deaths caused by self-directed violence in 2013 were approximately $93.5 billion after adjusting for under-reporting of suicide (Shepard, Gurewich, Lwin, Reed, & Silverman, 2016). The overwhelming burden of these costs results

Comment [A]: From TS: I found this wording somewhat awkward.

Comment [A]: From LLD: The Crosby & Sacks reference is missing from the reference list. I looked it up online and noticed that the 13 million estimate is based on knowing a suicide decedent in the past year. Knowing someone who died by suicide seems potentially broader to me than being directly impacted.

Comment [A]: From TS: Has anyone updated this? It would be good to check.

Comment [A]: From LLD: they may also be impacted in other ways (e.g., loss of family income, etc.)

Comment [A]: From TS: It seems like it would be appropriate to acknowledge the CDC estimate too. Consider using that as a minimum and then say that others have estimated that the costs could be considerably higher after adjusting for under-reporting of suicide.

from lost productivity over the life course, with the average cost per suicide being over $1.3 million (Shepard et al., 2016).

Suicide can be prevented. Despite the myths surrounding suicide, like most public health problems, suicide is preventable (U.S. Public Health Service, 1999). And while progress will continue to be made into the future, evidence for numerous programs, practices, and policies currently exists, and many programs are ready to be implemented now. Just as suicide is not caused by a single factor, research suggests that suicide will not be prevented by any single intervention taking place in any single setting (Silverman & Maris, 1995; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Rather, suicide prevention is best achieved by a focus across the individual, relationship, family, community, and societal-levels and across all sectors, private and public (e.g., business, public health, physical and behavioral healthcare, justice, education, labor) (National Action Alliance for Suicide Prevention, 2014; World Health Organization, 2014).

Assessing the Evidence

This technical package includes programs, practices, and policies with evidence of impact on suicide or risk or protective factors for suicide. To be considered for inclusion in the technical package, the program, practice, or policy selected had to meet at least one of these criteria: a) meta-analyses or systematic reviews showing impact on suicide; b) evidence from at least one rigorous (e.g., randomized controlled trial [RCT] or quasi-experimental design) evaluation study that found significant preventive effects on suicide; c) meta-analyses or systematic reviews showing impact on risk or protective factors for suicide, or d) evidence from at least one rigorous (e.g., RCT or quasi-experimental design) evaluation study that found significant impacts on risk or protective factors for suicide. Finally, consideration was also given to the likelihood of achieving beneficial effects on multiple forms of violence; no evidence of harmful effects on specific outcomes or with particular subgroups; and feasibility of implementation in a U.S. context if the program, policy, or practice has been evaluated in another country.

Within this technical package, some approaches do not yet have research evidence demonstrating impact on rates of suicide but instead are supported by evidence indicating impacts on risk or protective factors for suicide (e.g., help-seeking, stigma reduction, depression, connectedness). In terms of the strength of the evidence, programs that have demonstrated effects on suicidal behavior (e.g., reductions in deaths, attempts) provide a higher-level of evidence, but the evidence base is not that strong in all areas. For instance, there has been less evaluation of community engagement and family programs on suicidal behavior. Thus, approaches in this package that have effects on risk or protective factors reflect the developing ~~mental~~ nature of the evidence base and the use of the best available evidence at a given time.

It is also important to note that there is often significant heterogeneity among the programs, policies, or practices that fall within one approach or strategy area in terms of the nature and quality of the available

Comment [A]: From TS: "developmental nature" doesn't seem correct. Do you mean the "current status"

evidence. Not all programs, policies, or practices that utilize the same approach (e.g., gatekeeper training) are equally effective, and even those that are effective may not work across all populations. Tailoring programs and more evaluation may be necessary to address different population groups. The examples provided are not intended to be a comprehensive list of evidence-based programs, policies, or practices for each approach, but rather illustrate models that have been shown to impact suicide or have beneficial effects on risk or protective factors for suicide. In practice, the effectiveness of the programs, policies and practices identified in this package will be strongly dependent on the quality of their implementation and the communities in which they are implemented. Implementation guidance to assist practitioners, organizations and communities will be developed separately.

Context and Cross-Cutting Themes

The strategies and approaches that have been included in this technical package represent different levels of the social ecology, with efforts intended to impact the community and societal levels, as well individual and relationship levels. The strategies and approaches are intended to work in combination and reinforce each other to prevent suicide (see box below). The strategies are arranged in order such that those strategies hypothesized to have the greatest potential for broad public health impact on suicide are included first, followed by those that might impact more select populations (e.g., persons who have already made a suicide attempt).

Preventing Suicide	
Strategy	**Approach**
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access to mental health care	• Coverage of mental health conditions in health insurance policies
Create protective environments	• Reducing access to lethal means among persons at-risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm approaches • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning • Parenting skill and family relationship approaches
Identify and support people at risk	• Gatekeeper training • Screening combined with care management

	• Crisis intervention
Intervene to lessen harms and prevent future risk	• Treatment for people at-risk of suicide • Treatment to prevent re-attempts • Postvention • Safe messaging following a suicide

The example programs, policies, and practices have been implemented within particular contexts. The social and cultural context of communities is critically important to take into account when selecting strategies and approaches. Practitioners in the field may be in the best position to assess the needs and strengths of their communities and work with community members to make decisions about the combination of approaches included here that are best suited to their context.

Suicide ideation, attempts, morbidity and mortality vary by gender, race/ethnicity, age, occupation, and other important population characteristics. Barriers to disclosure, help seeking, timely access to quality care, and ongoing support may also vary by population and community characteristics. Ideally, the availability of multiple approaches tailored to the economic, cultural, and environmental context of individuals and communities are desirable as they may increase the likelihood of removing barriers to supportive and effective care and provide opportunities to develop individual and community resilience. These culturally appropriate approaches can then be included in comprehensive strategies to maximize the public health impact on reducing suicide-related morbidity and mortality among individuals and within communities.

This package includes strategies where public health agencies are well positioned to bring leadership and resources to implementation efforts. It also includes strategies where public health can serve as an important collaborator (e.g., strategies addressing community and societal level risks), but where leadership and commitment from other sectors such as business, labor or health care is critical to implement a particular policy or program (e.g., workplace policies; screening combined with care management). The role of various sectors in the implementation of a strategy or approach in preventing suicide is described further in the section on *Sector Involvement*.

In the sections that follow, the strategies and approaches with the best available evidence for preventing suicide are described.

Strengthen Economic Supports

Rationale

Studies from the U.S. examining historical trends indicate that suicide rates increase during economic recessions marked by high unemployment rates, job losses, and economic instability and decrease during economic expansions and periods marked by low unemployment rates, particularly for working-age individuals 25 to 64 years old (Luo et al., 2011; Fowler et al., 2015). Economic and financial strain, such as job loss, long periods of unemployment, reduced income, difficulty covering medical, food, and housing expenses, and even the anticipation of such financial stress, can directly ~~or indirectly~~ increase an individual's risk for suicide or indirectly increase risk by exacerbating related physical and mental health problems; buffering these risks can therefore, potentially protect against suicide (Stack & Wasserman, 2007). For example, strengthening economic support systems can help people stay in their homes or obtain affordable housing while also paying for necessities such as food and medical care, job training, child care, among other expenses required for daily living. In providing this support, stress and anxiety and the potential for a crisis situation may be reduced, thereby preventing suicide.

Approaches

Economic supports for individuals and families can be strengthened by targeting household financial security and ensuring stability in housing during periods of economic stress.

- **Strengthening household financial security** can potentially buffer the risk of suicide by providing individuals with the financial means to lessen the stress and hardship associated with a job loss or other unanticipated financial problems. The provision of unemployment benefits and other forms of temporary assistance, livable wages, medical benefits, and retirement and disability insurance to help cover the cost of necessities or to offset costs in the event of disability, are examples of ways to strengthen household financial security.

- **Housing stabilization policies** aim to keep people in their homes and provide housing options for those in need during times of financial insecurity. This may occur through programs that provide affordable housing such as through government subsidies or through other options available to potential homebuyers such as loan modification programs, move-out planning, or financial counseling services that help minimize the risk or impact of foreclosures and eviction.

Potential Outcomes

- ~~Reduced~~ Reductions in suicide rates
- ~~Lower~~ Reductions in foreclosure rates
- Reductions in~~Lower~~ eviction rates
- ~~Reduced~~ Reductions in emotional distress

Comment [A]: From TS: I was thinking that it might be good to work in a point about how these risks can be directly or indirectly associated with suicide risk because these stressors can exacerbate relationship as well physical and mental health problems.

KH: Agreed. Added some language.

Comment [A]: From JH: Consistent tense – reduced vs. reduce

Comment [A]: From LLD: the other packages use "Reductions in..."; you may want to consider using similar language for your potential outcomes.

KH: Made consistent throughout.

Evidence

There is evidence suggesting that strengthening household financial security and stabilizing housing can reduce suicide risk.

- **Strengthen household financial security.** An examination of variations in U.S. *unemployment benefit programs* across states demonstrated that the impact of unemployment on suicide was offset in those states that provided greater than average unemployment benefits (Cylus, Glymour, & Avendano, 2014). Another U.S. study examining the link between unemployment and suicide risk using monthly suicide data, length of unemployment, and job losses found that the duration of unemployment, as opposed to just the loss of job, predicted suicide risk (Classen & Dunn, 2012). Together, these results suggest that not only should state unemployment benefit programs be generous in their financial allocations, but also in their duration.

  Other measures to strengthen household financial security (e.g., transfer payments related to retirement and disability insurance, unemployment insurance compensation, medical benefits, and other forms of family assistance) have also shown an impact on suicide. A study by Flavin and Radcliff (2009) examined the impact of states' per capita spending on transfer payments, medical benefits, and family assistance (Temporary Assistance to Needy Families – TANF) and total state spending on suicide rates between 1990-2000, controlling for a number of suicide risk factors (e.g., residential mobility, divorce rate, unemployment rate) at the state level. As per capita spending on total transfer payments, medical benefits, and family assistance increased there was an associated decrease in state suicide rates. Moreover, it wasn't spending in general that was associated with the reduction but spending on these types of assistance. In terms of lives saved, Flavin & Radcliff calculated the cost of reducing a state's suicide rate by a full point for the years studied. At the national level, they estimated that 3,000 fewer suicides would occur per year nationwide if every state increased ~~their~~its per capita spending on these types of assistance by $45 per year (Flavin & Radcliff, 2009). Although this was a correlational study, the results demonstrate the potential benefits of policies that reach particularly vulnerable individuals during periods of great need and increased risk for suicide. More evaluation studies are needed to further understand the outcomes impacted by programs such as these.

- **Housing stabilization policies.** The *National Neighborhood Stabilization Program* was designed to help neighborhoods suffering from high rates of foreclosure and abandonment by slowing the deterioration of the neighborhoods and providing affordable housing options for low, moderate, and middle-income homebuyers. This program also offers financial assistance to eligible individuals for the purchase of a new home. Although this program has not been rigorously evaluated for its impact on suicide outcomes, it addresses foreclosure and eviction, which are

Comment [A]: From TS: Consider including a point about this being a correlational study and more evaluation work is needed but it suggests the potential benefits of policies that reach those who are particularly vulnerable at the times when they are in greatest need.

KH: Added language to indicate this.

risk factors for suicide. A longitudinal analysis of annual data on suicides and foreclosures demonstrated that as the proportion of foreclosed properties increased in U.S. states, so did the state suicide rate, particularly among working-aged adults (Houle & Light, 2014). Another study of data from 16 U.S. states participating in the National Violent Death Reporting System found that suicides precipitated by home foreclosures and evictions increased more than 100% from 2005 (before the housing crisis began) to 2010 (after it had peaked; Fowler, Gladden, Vagi, Barnes, and Frazier (2015)). Most of these suicides occurred prior to the actual loss of the decedent's home. These findings suggest that integrating suicide prevention resources, messaging, and referrals into financial, foreclosure, and move-out planning and counseling services may help to prevent suicide.

Strengthen Access to Mental Health Care

Rationale

While most people with mental health problems do not attempt or die by suicide (Olfson, Gerhard, Huang, Crystal, & Stroup, 2015; Owens, 2002), and the level of risk~~risk~~ conferred by different types of mental illnesses ~~differ~~ varies (Arsenault-Lapierre, Kim, & Turecki, 2004; E. C. Harris & Barraclough, 1997; Tyrer, Reed, & Crawford, 2015), previous research indicates that mental illness is an important risk factor for suicide (E. C. Harris & Barraclough, 1998; World Health Organization, 2014). Studies suggest that up to 90% of people who die by suicide may have had a mental illness or substance abuse problems at the time of their deaths (Arsenault-Lapierre et al., 2004; Cavanagh, Carson, Sharpe, & Lawrie, 2003; Isometsa, 2001). State-level suicide rates have also been found to be correlated with general mental health measures such as depression (Lang, 2013; Mark, Shern, Bagalman, & Cao, 2007). Findings from the National Comorbidity Survey indicate that relatively few people in the U.S. with mental health disorders receive treatment for those conditions (Kessler et al., 2005). Lack of access to mental health care is one of the contributing factors related to the underuse of mental health services (Cunningham, 2009). Identifying ways to improve access to timely, affordable, and quality mental health care for people in need is a critical component to suicide prevention (World Health Organization, 2014). Apart from the treatment benefits, it can also serve to normalize help-seeking behavior and increase the use of such services.

Approaches

One approach to strengthening access to mental health care is through the provision of mental health coverage in health insurance policies.

- **Coverage of mental health conditions in health insurance policies.** Federal and state laws include provisions for equal coverage of mental health services in health insurance plans that is on par with coverage for other health concerns (i.e., mental health parity). Benefits and services covered include such things as the number of visits, co-pays, deductibles, inpatient/outpatient services, prescription drugs, and hospitalizations. If a state has a stronger mental health parity law than the federal parity law, then insurance plans regulated by the state must follow the state parity law. ~~Federal parity replaces the state law only in cases where the state law prevents the application of the federal parity law (e.g., includes coverage for some mental health conditions but not others).~~ If a state has a weaker parity law than the federal parity law (e.g., includes coverage for some mental health conditions but not others), then the federal parity law will replace the state law. Equal coverage does not necessarily imply good coverage as health insurance plans vary in the extent to which benefits and services are offered to address various health conditions. Rather it helps to ensure that mental health services are covered on par with other health concerns.

Comment [A]: From JM: I assume this means that different types of mental health problems pose different risks for suicide, but wasn't sure? May want to make the point more explicit

KH: Yes – added some language that I think helps to clarify this point.

Comment [A]: From TS: Isn't this including substance abuse disorder? It would be good to state this explicitly.

Yes - Added.

Comment [A]: From TS: I found this sentence confusing. Can you reword to simplify this.

From LLD: could say: "if a state has a weaker parity law than the federal parity law (e.g., includes coverage for some mental health conditions but not others), then the federal parity law will replace the state law."

Thanks, Linda. Accepted your suggestion.

Potential Outcomes

- ~~Increased~~ Increases in utilization of mental health services
- ~~Decreased~~ Reductions in symptoms of mental illnesses
- ~~Decreased~~ Reductions in rates of suicide attempts
- ~~Decreased~~ Reductions in rates of suicide

Evidence

There is evidence suggesting that coverage of mental health conditions in health insurance policies can reduce risk factors associated with suicide and may directly impact suicide rates.

- **Coverage of mental health conditions in health insurance policies.** The National Survey of Drug Use and Health is a nationally representative survey of the U.S. population that provides data on substance use, mental health conditions, and services utilization. Using data from this survey, K. M. Harris, Carpenter, and Bao (2006) found that 12 months after states enacted *mental health parity laws*, self-reported use of mental healthcare services significantly increased. Moreover, subsequent research by Lang (2013) examined state mental health laws and suicide rates between 1990 and 2004 and found that mental health parity laws, specifically, were associated with an approximate 5% reduction in suicide rates. This reduction, in the 29 states with parity laws, equated to the prevention of 592 suicides per year. Lang et. al (2013) estimated the cost of saving a life through such mandates as mental health parity by comparing the loss in wages attributable to the policy, via increased premiums, to the number of lives saved. Based on these calculations, the cost of saving one life was between ~~a cost savings of~~ $1.3-3.1 million per suicide prevented. However, this calculation did not take into account the saving associated with improved mental health among non-suicidal individuals, increases in productivity, or quality of life associated with increased mental health care. As such, this figure is considered the upper bounds on costs incurred and should be interpreted with caution (Lang, 2013).

Comment [A]: From TS: I don't think this is accurate. I was curious about this study and checked out the paper. I think they are saying that this is the cost incurred per suicide prevented. They go on to explain that this is the upper bound and does not reflect the benefits to non-suicidal individuals. Please confirm this. If you are going to include this then it will be important to explain it further.

Create Protective Environments

Rationale

Prevention efforts that focus not only on individual behavior change (e.g., help-seeking, treatment interventions) but on changes to the environment can increase the likelihood of positive behavioral and health outcomes (Haddon, 1980). Creating environments that address risk and protective factors where individuals live, work, and play, can help prevent suicide (Dahlberg & Krug, 2002; U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). For example, rates of suicide and suicide attempts are elevated in certain occupational groups (Han et al., 2016; McIntosh et al., 2016), therefore, changes to the organizational culture in these occupations, by way of implementation of supportive policies or even physical modifications to the workplace environment, can change social norms, encourage help-seeking, and demonstrate that good health and mental health are valued and that stigma and other risk factors for suicide are not (K. L. Knox et al., 2010; National Action Alliance for Suicide Prevention Workplace Task Force, 2015). Similarly, modifying the characteristics of the environment to prevent harmful behavior such as access to lethal means can reduce suicide rates, particularly in times of crisis (Beautrais, Gibb, Fergusson, Horwood, & Larkin, 2009; A.E. Crosby, Espitia-Hardeman, Ortega, & Lozano, 2013; Kaplan et al., 2013; Miller, Warren, Hemenway, & Azrael, 2015; C. W. Runyan et al., 2016).

Approaches

The current evidence suggests three ~~promising~~ potential approaches for creating environments that protect against suicide.

- **Reducing access to lethal means among persons at-risk of suicide.** Means of suicide such as firearms, hanging/suffocation, or jumping from heights provide little opportunity for rescue and, as such, have high case fatality rates (e.g., about 85% of people who use a firearm in a suicide attempt will die from the injury). Research also indicates that 1) the interval between thinking about and attempting suicide can be as short as 5 or 10 minutes (Deisenhammer et al., 2009; Simon et al., 2001) and 2) that people tend *not* to substitute a different method when a highly lethal method is unavailable or difficult to access (Hawton, 2007; Yip et al., 2012). Therefore, increasing the time interval between the thought and the suicide attempt, for example, by making it more difficult to access lethal means, can be lifesaving. The following are examples of approaches reducing access to lethal means for persons at-risk of suicide:

    - *Intervening at Suicide Hotspots.* Suicide hotspots, or places where suicides may take place relatively easily, include tall structures (e.g., bridges and cliffs), railway tracks, and isolated locations such as parks. Efforts to prevent suicide at these locations include

Comment [A]: From JM: The word promising has certain connotations when using it around evidence. You say later that the evidence around this strategy is some of the strongest for suicide. These two statements seem somewhat inconsistent. I would use a different word here then promising if you truly believe there is strong evidence.

From JH: suggest deleting the word "promising"

From LLD: since we don't want to infer that these are the only approaches for creating protective environments, I might be inclined to change the word "promising" to "potential" or "possible" or something along those lines.

KH: Thank you for the suggestions.

erecting barriers to prevent jumping and installing signs and telephones to encourage individuals who are considering suicide, to seek help (Cox et al., 2013).

- *Safe Storage Practices.* Safe storage of medications, firearms, and other household products can reduce the risk for suicide by separating individuals who may be vulnerable and/or impulsive from easy access to lethal means. Such practices may include education and counseling around storing firearms--locked in a secure place (e.g., in a gun safe or lock box), unloaded and separate from the ammunition--and keeping medicines in a locked cabinet or other secure location away from people who may be at risk or who have made prior attempts (Rowhani-Rahbar, Simonetti, & Rivara, 2016; C. W. Runyan et al., 2016).

- **Organizational policies and culture** that promote protective environments may be implemented in places of employment. Such policies and cultural values may promote prosocial behavior (e.g., asking for help), skill building, changing social norms, referral and access to helping services (e.g. mental health, substance abuse treatment, financial counseling), and encourage leadership support from the top down. Such policies and cultural shifts can positively impact organizational climate and morale and help prevent suicide and its related risk factors (e.g. depression, social isolation) (National Action Alliance for Suicide Prevention Workplace Task Force, 2015).

- **Community-based policies to reduce excessive alcohol use.** Research studies in the United States have found that greater alcohol availability is positively associated with alcohol-involved suicides (Escobedo & Ortiz, 2002; Giesbrecht et al., 2015). Policies to reduce excessive alcohol use broadly include zoning to limit alcohol outlet locations and density, taxes on alcohol, and bans on the sale of alcohol for individuals under the legal drinking age. These policies are important because acute alcohol use has been found to be associated with more than one-third of suicides and approximately 40% of suicide attempts (Cherpitel, Borges, & Wilcox, 2004).

Potential Outcomes

- Increases in safe storage of means
- Reductions in suicide attempts
- Reductions in suicide deaths
- Increases in help-seeking
- Reductions in alcohol-related suicide deaths

Evidence

The evidence for the effectiveness of preventing suicide by reducing access to lethal means ~~for person at-risk of suicide~~ and ~~other ways to~~ otherwise establishing protective environments for individuals at

risk of suicide is strong, particularly compared to existing evidence for other prevention strategies ~~is some of the strongest in the field~~ (Zalsman et al., 2016).

Comment [A]: From JM: Consistent with promising used earlier? Is it the strongest?

I think it is consistent with promising, but we changed that to potential. The interpretation from the paper states " no single strategy clearly stands above the others", so I would be hesitant to call it out as the strongest evidence, but it definitely may be for certain populations. Modified to simply indicate that it is strong.

- **Reducing access to lethal means among persons at-risk of suicide.** A meta-analysis examining the impact of *suicide hotspot interventions* implemented in combination or in isolation, both in the U.S. and abroad, found associated reduced rates of suicide (Cox et al., 2013; Pirkis et al., 2015). For example, after erecting a barrier on the Jacques-Cartier bridge in Canada, the suicide rate from jumping from the bridge decreased from about 10 suicide deaths per year to about 3 deaths per year (Perron, Burrows, Fournier, Perron, & Ouellet, 2013). Moreover, the reduction in suicides by jumping was sustained even when all bridges and nearby jumping sites were considered, suggesting little to no displacement of suicides to other jumping sites (Perron et al., 2013). Further evidence for the effectiveness of bridge barriers was demonstrated by a study examining the impact of the *removal* of safety barriers from the Grafton Bridge in Auckland, New Zealand. After removal of the barrier, both the number and rate of suicide increased fivefold (Beautrais, 2001; Beautrais et al., 2009).

  Another form of means reduction involves implementation of *safe storage practices*. In a case-control study of firearm-related events identified from 37 counties in Washington, Oregon, and Missouri, and from 5 trauma centers, Grossman et al. (2005) found that storing firearms unloaded, separate from ammunition, in a locked place or secured with a safety device was protective of suicide attempts among adolescents. Further, a recent systematic review of clinic and community-based education and counseling interventions suggested that the provision of safety devices significantly increased safe firearm storage practices compared to counseling alone or compared to the provision of economic incentives to acquire safety devices on one's own (Rowhani-Rahbar et al., 2016).

  Another program, The *Emergency Department Counseling on Access to Lethal Means (ED CALM)*, trained psychiatric emergency clinicians in a large children's hospital to provide lethal means counseling and safe storage boxes to parents of patients under age 18 receiving care for suicidal behavior. In a pre-post quality improvement project, Runyan et al (2016) found that at post-test 76% (of the 55% of parents followed up, n=114) reported that all medications in the home were locked up as compared to fewer than 10% at the time of the initial emergency department visit. Among parents who indicated the presence of guns in the home at pre-test (i.e. 67%), all (100%) reported guns were currently locked up at post-test (C. W. Runyan et al., 2016).

- **Organizational policies and culture.** *Together for Life* is a workplace program of the Montreal Police Force implemented to address suicide among officers. Policy and program components were designed to foster an organizational culture that promoted mutual support and solidarity among all members of the Force. The program included training of supervisors, managers and

all units to improve competencies in identifying suicidal risk and to improve use and awareness of existing resources. The program also included an education campaign to improve awareness and help-seeking (Mishara & Martin, 2012). Police suicides were tracked over 12 years and compared to rates in the control city of Quebec. The suicide rate in the intervention group decreased significantly by 78.9% to a rate of 6.4 suicides per 100,000 population per year compared to an 11% increase in the control city (29.0 per 100,000) (Mishara & Martin, 2012).

Another example of this approach is the *United States Air Force Suicide Prevention Program (AFSPP).* AFSPP included 11 policy and education initiatives and was designed to change the culture of the Air Force surrounding suicide. The program uses leaders as role models and agents of change, establishes expectations for behavior related to awareness of suicide risk, develops population skills and knowledge (i.e., education and training), and investigates every suicide (i.e., outcomes measurement). The program represents a fundamental shift from viewing suicide and mental illness solely as medical problem and instead sees them as larger service-wide problems impacting the whole community (K. L. Knox, Litts, Talcott, Feig, & Caine, 2003). Using a time-series design to examine the impact of the AFSPP program on various violence-related outcomes, researchers found that the program was associated with a 33% relative risk reduction in suicide (K. L. Knox et al., 2003).The program was also associated with relative risk reductions in related outcomes including moderate and severe family violence (30% and 54%, respectively), homicide (51%), and accidental death (18%) (K. L. Knox et al., 2003). A longitudinal assessment of the program over the period 1981 to 2008 (16 years before the 1997 launch of the program and 11 years post-launch) found significantly lower rates of suicide after the program was launched than before (K. L. Knox et al., 2010). These effects were sustained over time, except in 2004, which the authors found was associated with less rigorous implementation in that year than in the other years (K. L. Knox et al., 2010).

- **Community-based policies to reduce excessive alcohol use.** While multiple policies to limit excessive use of alcohol exist, several studies on alcohol outlet *density*, specifically, suggest that measures to reduce alcohol outlet density can potentially reduce alcohol-involved suicides. Additionally, a longitudinal analysis of alcohol outlet density, suicide mortality, and hospitalizations for suicide attempts over 6 years in 581 California zip codes indicated that the density of bars, specifically, is related to suicide and suicide attempts, particularly in rural areas (Johnson, Gruenewald, & Remer, 2009).

Promote Connectedness

Rationale

Sociologist, Emile Durkheim theorized in 1897 that weak social bonds, i.e. lack of connectedness, are among the chief causes for suicidality (Durkheim, 1897/1951). *Connectedness* is the degree to which an individual or group of individuals are socially close, interrelated, or share resources with others (Centers for Disease Control and Prevention, 2009). Social connections can be formed within and between multiple levels of the social ecology (Dahlberg & Krug, 2002), for instance between individuals (e.g. peers, neighbors, co-workers), families, schools, neighborhoods, workplace, faith communities, cultural groups, and society as a whole. Related to connectedness, *social capital* refers to a sense of trust in one's community and neighborhood, social integration, and also the availability and participation in social organizations (Beyer, Layde, Hamberger, & Laud, 2015; Muennig, Cohen, Palmer, & Zhu, 2013). Many ecological cross-sectional and longitudinal studies have examined the impact of aspects of social capital on depression symptoms, depressive disorder, mental health more generally, and suicide. While the evidence is ~~still being built~~limited, existing studies suggest the pattern is towards a positive ~~n inverse~~ association between social capital measured by social trust, community/ neighborhood engagement, and improved mental health. Connectedness and social capital together can serve to protect against suicidal behaviors by decreasing isolation, encouraging adaptive coping behaviors, increasing belongingness, personal value and worth all of which helps individuals to build resilience in the face of adversity. Connectedness can also provide individuals with better access to formal supports and resources, mobilize communities to meet the needs of its members and provide collective primary prevention activities to the community as a whole (Centers for Disease Control and Prevention, 2009).

Approaches

Promoting connectedness among individuals and within communities through modeling peer norms and enhancing community engagement can protect against suicide.

- **Peer norm approaches** seek to normalize ~~prosocial behaviors/~~protective factors for suicide such as help-seeking, reaching out and talking to trusted adults, and promote peer connectedness. These approaches typically target youth and are delivered in school settings but can also be implemented in community settings.

Comment [A]: From JM: Seems like a nuance you can delete from this paragraph. You don't really pick up on this later and it probably requires more explanation

Comment [A]: From JH: Awkward wording. Consider, while the evidence is limited, existing studies suggest…

Comment [A]: From JM: This implies that prosocial behavior is currently abnormal. Maybe promote is a better word?

From JH: suggest deleting "seek to normalize" and say "Peer norm approaches encourage prosocial behavior…"

Comment [A]: I prefer to keep it as normalize and took out prosocial behavior. We want to normalize help-seeking versus making it seem like a personal weakness.

- **Community engagement activities**. Community engagement is an aspect of social capital. Community engagement approaches may involve residents participating in a range of activities, including religious activities, community clean-up and greening activities, and physical exercise. These activities provide opportunities for residents to become more involved in the community and to connect with other community members, organizations, and resources, resulting in enhanced overall physical health, reduced stress, and decreased depressive symptoms, thereby reducing risk of suicide.

Potential Outcomes

- Reductions in maladaptive coping attitudes and behaviors
- Increases in healthy coping attitudes and behaviors
- Increases in referrals for youth in distressed
- Increases help-seeking behaviors
- Increases in p~~P~~ositive perceptions of adult support

Evidence

Current evidence suggests that peer norm approaches and community engagement can reduce risk factors associated with suicidal behaviors.

- **Peer norm approaches.** Evaluations show that programs such as *Sources of Strength* can improve school norms and beliefs about suicide that are created and disseminated by student peers. In a randomized controlled trial of *Sources of Strength* conducted with 18 high-schools (6 metropolitan, 12 rural), Wyman et al. (2010) found that the program improved ~~peer leaders'~~ adaptive norms regarding suicide among peer leaders, ~~their~~ connectedness to adults, and school engagement. Peer leaders were also more likely than controls to refer a suicidal friend to an adult. ~~Among students, the intervention~~ For students, the program resulted in increased perceptions of adult support for suicidal youths, particularly among those with a history of suicidal ideation, and the acceptability of help-seeking behaviors ~~seeking help~~. ~~Perception of adult support increased most in students with a history of suicidal ideation.~~ Finally, trained peer leaders also reported a greater decrease in maladaptive coping attitudes compared with untrained leaders (Wyman et al., 2010). More evaluation research is needed to examine whether these improvements in factors that protect against suicidal behavior translate into reduced suicidal behavior and suicide.

- **Community engagement activities.** A vacant lot greening initiative was undertaken in Philadelphia between 1999 and 2008. Local residents and community members worked together to green 4,436 lots (or 7.8 million square feet) in 4 areas of the city. Researchers found significant ~~associated~~ reductions in community residents' self-reported level of stress, which is a risk factor

Comment [A]: From JH: Cite findings from Let's Connect intervention program? While the intervention didn't significantly reduce suicidal behavior, there were significant improvements in connectedness (a protective factor for suicide).

KH: This is a great thought. We have quite a few programs that didn't reduce suicidal behavior, but do impact related RFs, so we're trying to stray from them and focus on those that impacted suicide and attempts or have a greater amount of evidence/more evaluations behind them.

Comment [A]: From TS: Is there any evidence on outcomes more proximal to suicide? Did they look for any and not find them? It is important to describe relevant null effects when they were found.

KH: They did not look at more proximal outcomes, but SOS is currently undergoing a 6-year evaluation funded by NIMH to examine impact, hopefully with suicidal behaviors being one of the outcomes they're measuring.

for suicide,~~stress levels~~ and engagement in more physical exercise, a protective factor for suicide, than residents in control vacant lot areas. Other benefits included reductions in firearm assaults and vandalism (Branas et al., 2011).

Teach Coping and Problem-Solving Skills

Rationale

Building life skills prepares individuals to successfully tackle every day challenges and adapt to stress and adversity. Life skills encompasses many concepts, but most often include coping and problem-solving skills, conflict resolution, and critical thinking. Life skills are important in shielding individuals from suicidal behaviors (World Health Organization, 2014). Suicide prevention programs that focus on life and social skills training are drawn from social cognitive theories (Bandura, 1986), surmising that suicidal behavior is attributed to either direct learning, modeling, ~~and~~ or environmental and individual (e.g. hopelessness) characteristics. The literature linking life skills and suicide is robust. The inability to employ adequate strategies to cope with immediate stressors or identify and find solutions for problems has been characterized among suicide attempters (Pollock & Williams, 2004). Treatments that include bolstering skills (Goldsmith, Pellmar, Kleinman, & Bunney, 2002) and include problem-solving techniques (Ghahramanlou-Holloway, Bhar, Brown, Olsen, & Beck, 2012; Townsend et al., 2001) appear to reduce suicidal ideation and attempts more effectively. Prevention programs focused on teaching these skills target youth, parents and families and have been used with both universal and at-risk populations. While many do not target suicidal behaviors directly, these programs strive to train youth and parents in important life skills to offset the underlying vulnerabilities that contribute to engaging in high-risk behaviors early in life.

Approaches

Current evidence provides support for the following two approaches:

- **Social emotional learning programs** focus on developing and strengthening communication and problem-solving skills, emotion regulation, conflict resolution, help seeking and coping skills. These approaches address a range of risk and protective factors for suicidal behavior. They provide children and youth with skills to resolve problems in relationships, school, and with peers, and help youth to address other negative influences (e.g., substance use) associated with suicide. These approaches are typically delivered to all students in a particular grade or school, although some programs also focus on groups of students considered to be at high risk for suicide. Opportunities to practice and reinforce skills are an important part of programs that work (Herman, Borden, Reinke, & Webster-Stratton, 2011).

Comment [A]: From JM: Not seeing strong evidence here. Are you suggesting that this affects documented risk factors for suicide by reducing stress and increasing physical exercise? I would like to see a stronger evidence statement here.

From LLD: you might want to incorporate a phrase in the statement along the lines of "which are risk factors for suicide"

KH: Added the qualifier you suggested, Linda.

Comment [A]: From TS: They had a follow up paper in 2013 that showed intervention sites felt significantly safer. The effects on crimes was encouraging but not significant. It seems important to mention this too.

From LLD: not sure I agree with Tom's last point about mentioning the nonsignificant effect on crime.

Comment [A]: From LLD: the word "either" here implies another comparative clause; should the word "or" be inserted before the word "modeling"? May want to just delete the word "either"

KH: Added.

- **Parenting skill and family relationship programs** are designed to strengthen parenting skills, enhance positive parent-child interactions, and improve children's behavioral and emotional skills and abilities. Several parenting and family relationship programs have been shown in rigorous evaluations to improve resilience and reduce risk factors for various behaviors, including ones closely related to suicide, such as depression, internalizing behaviors, and substance abuse (M. S. Knox, Burkhart, & Hunter, 2010).

Potential Outcomes

- Reductions in suicide attempts and suicide ideation
- Improvements in ~~Enhanced~~ knowledge of risk and protective factors associated with suicide
- Reductions in suicide risk behaviors (i.e., depression, anxiety, conduct problems, substance abuse)
- Improvements in ~~and normalize~~ help-seeking behavior
- Improvements~~Enhance~~ in social competence and emotional regulation skills
- Improvements~~Enhance~~ in problem-solving and conflict management skills

Evidence

There are several programs with evidence that support teaching social, emotional and parenting skills to reduce suicidal behaviors and associated risk factors.

- **Social emotional learning programs.** The *Youth Aware of Mental Health Program (YAM)* is a program developed for teenagers that uses interactive dialogue and role-playing to teach adolescents about the risk and protective factors associated with suicide (including knowledge about depression and anxiety) and enhances their problem-solving skills for dealing with adverse life events, stress, school and other problems. The program includes 3 hours of role-play sessions and interactive workshops combined with a booklet that students can keep, educational posters displayed in classroom, and interactive lectures about mental health at the beginning and end of the program (Wasserman et al., 2014). In a cluster-randomized controlled trial of YAM conducted across 10 European Union countries and 168 schools, students aged 14-16 participating in the YAM program were significantly less likely to ~~have an incident suicide attempt (OR 0.45, 95%CI 0.24–0.85; p=0.014)~~ attempt suicide and ~~-~~have severe suicidal ideation ~~(0.50, 0.27-0.92; p=0.025)~~ at the 12-month follow-up compared to the control group which did not participate in an intervention. Overall, the relative risk of youth suicide attempts among the YAM group was reduced by over 50%, ~~indicating~~demonstrating that out of 1000 students, five attempted suicide in the YAM group compared to 11 in the control group. Additionally, related to severe suicide ideation, in the

Comment [A]: I think this should be this reference – 2015:
Wasserman, D., Hoven, C. W., Wasserman, C., Wall, M., Eisenberg, R., Hadlaczky, G., ... & Bobes, J. (2015). School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial. *The Lancet*, *385*(9977), 1536-1544.

Comment [A]: From JH: Report ages (compare to SOS below)

Comment [A]: From JH: Suggest translating OR and 95% CI for wider audience.

From LLD: agree; this is too technical for a wider audience. See Tom's suggestion below.

Revised accordingly

Comment [A]: From JH: state if the control group received any kind of intervention
Added

YAM group absolute risk fell by 0.50% and relative risk fell by 49.6% (Wasserman et al., 2014).

Signs of Suicide (SOS) is another school-based prevention program for students aged 13-17. The program includes guided classroom discussions about suicide and depression. As part of the program, students are screened for depression and suicide risk and referred for professional help as indicated. The program is designed to increase knowledge about suicide and risk factors associated with suicidal behavior as well as improve and normalize help-seeking behavior (Schilling, Aseltine, & James, 2016). In a randomized controlled trial, *SOS* was shown to reduce self-reported suicide attempts at 3-months post intervention among participating students compared to control students. The SOS program also increased students' knowledge of how to get help for themselves or friends for depression and/or suicidal thoughts, and favorable attitudes toward help-seeking. SOS participants with a lifetime history of suicide attempt were also less likely to report planning a suicide in the 3 months following the program compared to lower-risk participants (Schilling et al., 2016).

Finally, the *Good Behavior Game (GBG)* is a classroom-based program for elementary school children aged 6-10~~; it represents an example of upstream suicide prevention programming~~. The program uses a team-based behavior management strategy that promotes good behavior by setting clear expectations for good behavior and consequences for maladaptive behavior. The goal of the GBG is to create an integrated classroom social system that is supportive of all children being able to learn with little aggressive or disruptive behavior (Wilcox et al., 2008). Two cohorts of youths participated in the program in 1985-85 and 1986-86 school years when they were in the first and second grades. A number of proximal and distal outcomes were assessed among the two cohorts over time. With respect to distal suicide-related outcomes, ~~In a~~an outcome evaluation of the *GBG*, indicated that ~~first graders assigned~~individuals in the first cohort who were assigned to participate in ~~to~~ *GBG* when they were in the first grade reported half the adjusted odds of suicidal ideation and suicide attempts when assessed approximately 15 years later, between the ages of 19 to 21, compared to peers who had been in a standard classroom setting. The beneficial effect of the program was consistent for suicidal ideation regardless of whether baseline covariates were included. The *GBG* effect on attempts was less robust in some adjusted models including caregiver mental health. In the second cohort of *GBG* students, neither suicidal ideation nor suicide attempts were significantly different between *GBG* and the control interventions (Wilcox et al., 2008). ~~This~~ The authors surmise this finding likely arose due to the lack of implementation fidelity and pointed to the need for *GBG* to be delivered with precision, consistency, and teacher support. *GBG* was also found to be associated with reduced risk of later substance abuse, a risk factor for suicide (Kellam et al., 2008).

Comment [A]: From JH: significant?

Comment [A]: From TS: The Lancet paper has a 2015 publication date.

The authors provide the absolute and RR for suicide attempts too and they give a clear way of thinking about this – i.e., for RR "Of 1000 pupils, 11 attempted suicide in the control group vs five attempts in YAM"

It might be worth using the attempt example so you can provide this explanation.

Revised.

Comment [A]: From JH: significant? Effect size/magnitude of reduction?

Comment [A]: From JH: define control condition

Comment [A]: From JH: significant?

Comment [A]: From JH: Lower-risk? Do you mean students with no prior reported history of suicide attempts?

Comment [A]: From LLD: Jeff had questions about what is meant by upstream. You are referring to primary prevention but some of the other

Comment [A]: From JH: compared to?

Added.

Comment [A]: From JH: Suggest stating clearly there are two separate cohorts of students receiving the intervention. How do these cohorts differ (time, location)?

Comment [A]: From TS: It is important to help the reader to understand that this study looked at the suicidal ideation when the first graders were age 19-21. This is

Comment [A]: From JH: Is this the authors' comment or your interpretation of the data? Please clarify.

- **Parenting skill and family relationship programs.** Parenting and family skills training approaches have shown promising impacts in preventing key risk factors associated with suicide. For example, the *Incredible Years (IY)* is a comprehensive group training program for parents, teachers and children designed to reduce conduct and substance abuse problems, two important suicide risk factors, in youth by improving protective factors such as responsive and positive parent-teacher-child interactions and relationships, emotion self-regulation and social competence (all protective factors for suicide) (Herman et al., 2011). The program includes 9- 20 sessions offered in community-based settings (e.g., religious, recreation centers, mental health treatment centers, and hospitals). Several studies have demonstrated the effect of the *IY* program on reducing internalizing symptoms, such as anxiety and depression, and child conduct problems (C. H. Webster-Stratton, Reid, & Beauchaine, 2011; Webster-Stratton, Jamila Reid, & Stoolmiller, 2008). The program is also associated with improved problem-solving and conflict management; these skills were maintained at 1-year follow-up (Reid, Webster-Stratton, & Hammond, 2003; C. Webster-Stratton & Hammond, 1997; C. Webster-Stratton, Reid, & Hammond, 2001). The program demonstrated greater benefits as the dosage of the intervention increased (Herman et al., 2011).

  Additionally, *Strengthening Families 10-14* is a program that involves sessions between parents, youth, and family with the goal of improving parents' skills for disciplining, managing emotions and conflict, and communicating with their children; promoting youths' interpersonal and problem-solving skills; and creating family activities to build cohesion and positive parent-child interactions. The premise of the program is that developing these skills for both parents and children will reduce internalizing behavior and adolescent substance abuse, two important risk factors for suicide (Spoth, Guyll, & Day, 2002). *Strengthening Families* has been shown to significantly decrease externalizing behaviors, such as aggression, alcohol use, and drug use among youth participants ~~and~~, as well as reductions in depression, alcohol use, and drug use among participating families (Spoth et al., 2002).

Comment [A]: From JH: significant? Also please define externalizing behaviors.

KH Added

Comment [A]: From TS: This transition seems off.
KH: edited.

Identify and Support People At-Risk

Rationale

In order to decrease suicide, attention to people at increased ~~or high~~ risk, for example people with prior suicide attempts, is necessary, as these individuals tend to experience suicidal behavior at higher than average rates. These vulnerable or disadvantaged populations include, but are not limited to, individuals with lower socio-economic status or who are living with a mental health problem; people who have attempted suicide previously; individuals who are institutionalized, have been victims of violence, or are homeless; and members of certain racial and ethnic minority groups. Supporting these vulnerable groups requires proactive case finding along with access to, and retention in, mental health services. Finding effective ways of identifying at-risk or vulnerable groups, customizing services to make them accessible and engaged in care remain key challenges. For example, simply improving services does not guarantee that those services will be used by those most in need of them, nor will it necessarily increase the number of people who follow treatments that are recommended. People who are disadvantaged face social and economic issues that may adversely affect their ability to respond to the treatments or advice that are offered.

Comment [A]: From TS: This seems awkward as written. It might be better to say "...attention to people with specific vulnerabilities..."

Comment [A]: I'm not sure about 'specific vulnerabilities' terminology. I think people are much more familiar with something like this.

Approaches

The following three approaches focus on identifying and supporting people at increased risk.

- **Gatekeeper training** is designed to train teachers, coaches, providers and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating treatment seeking and support services. Gatekeeper training is typically implemented in schools to identify at-risk youth and within health care settings to identify adults (and youth).

- **Screening combined with care management and overall continuity of care** has been used in primary care and behavioral health care settings to assure that people who may be at high-risk of suicide are identified and receive ongoing treatment as needed, particularly after inpatient discharge and other transitions within the healthcare system so they don't 'slip through the cracks'. These approaches typically employ screening for depression and/or suicide combined with collaborative treatment planning between patients and their providers and patient follow-up.

- **Crisis intervention**. These approaches provide support and referral services, typically by connecting a person in crisis (or a friend or family member of someone at-risk) to trained volunteers or professional staff via telephone hotline, online chat, or text messaging. Crisis intervention approaches are intended to impact key risk factors for suicide, including feelings of

depression, hopelessness, and subsequent mental health care utilization. Like means reduction, crisis interventions can put space or time between an individual who may be considering suicide and harmful behavior.

Potential Outcomes

- Reductions in suicide attempts
- Reductions in suicide deaths
- ~~Increased~~ Increases in identification of individuals at-risk for suicidal behavior
- ~~Increased~~ Increases in at-risk individuals in treatment
- ~~Increased~~ Increases in community members trained to identify at-risk individuals
- ~~Increased~~ Increases in referrals for health care

Evidence

Identifying people at risk of suicide can positively impact both suicide risk factors as well as suicide mortality, however sustained implementation of programs and practices appears critical. Among people who identify *themselves* through calls to suicide hotlines, preliminary evidence finds reductions in suicide risk factors. ~~There is evidence that gatekeeper successful in reducing suicides but the efforts must be The number of studies evaluating crisis intervention services is limited, but decreased suicidal thoughts and behavior.~~

- **Gatekeeper training**. One example of gatekeeper training is the *Mental Health First Aid (MHFA)* program. This program is designed for the lay public and consists of three weekly sessions of three hours each. Participants learn the symptoms of people in mental health crises and/or in the early stages of mental health problems (i.e., those experiencing suicidal thoughts and behavior, acute stress reaction, panic attacks and acute psychotic behavior, and depression, anxiety, and psychotic disorders), possible risk factors, and where and how to get ~~evidence-based~~ effective help (Kitchener & Jorm, 2004). In a randomized controlled trial of 301 participants of *MHFA*, the intervention group, compared to the wait-listed control group, reported at 5 months follow-up, significantly greater feelings of confidence in helping someone (74.5% vs. 57.4%, p<.001), greater likelihood of encouraging people to seek professional help (29.4% vs. 16.8%, p<.007), improved agreement with health professionals about treatments (p<.036), and decreased stigmatizing attitudes towards mental illness (p<.02). Additionally, the intervention resulted in improved overall mental health of the participants themselves (p<.035). However, the percent who provided some or a lot of help did not differ between groups ((Kitchener & Jorm, 2004). Additional research rigorously evaluating *MHFA* for its impact on intervention recipients' suicidal behavior is needed (Kitchener & Jorm, 2006).

Comment [A]: From LLD: suggest shortening this introductory statement about the evidence and making it consistent with the other sections. If you need to provide caveats, then you might want to take a look at the YV TP for example wording.

Comment [A]: From TS: Add cites here. Also this wording is awkward because it could be read as suggesting that those who chose to use the hotline are different from others at risk who did not. Maybe you could add the follow up period to the end – they have decrease suicidal thoughts and behavior at xx

Comment [A]: From LLD: wording is a bit awkward here

Comment [A]: From JH: compared to?

Comment [A]: From JH: significant? Is it possible to report magnitude of intervention effects?

Comment [A]: From JH: Overall mental health or specific facets (e.g., depression, etc.)? Please clarify

Gatekeeper training has also been a primary part of all *Garret Lee Smith (GLS) Suicide Prevention Program* which is in place in 49 states and 48 tribes. A multi-site evaluation assessed the impact of community gatekeeper training on suicide attempts and deaths by comparing the change in suicide rates and nonfatal suicidal behavior among young people aged 10-24 in counties implementing *GLS* trainings, with the trajectory observed in similar counties that did not implement these trainings. Counties that implemented *GLS* trainings had significantly lower youth suicide rates one year following the training implementation (Walrath, Garraza, Reid, Goldston, & McKeon, 2015). This finding equates to a decrease of 1 suicide death per 100,000 among youth ages 10 to 24, or the prevention of approximately 237 deaths in the age group, between 2007 and 2010. Counties implementing *GLS* program activities, including gatekeeper training, also had significantly lower suicide attempt rates among youth ages 16 to 23 in the year following implementation of the *GLS* program than did similar counties that did not implement *GLS* activities (4.9 fewer attempts per 1000 youths; (Godoy Garraza, Walrath, Goldston, Reid, & McKeon, 2015)). More than 79,000 suicide attempts may have been prevented during the period examined, following implementation of the *GLS* program.

- **Screening combined with care management and overall continuity of care.** The *Henry Ford* healthcare system is a large health maintenance organization (HMO) in the state of Michigan. *Henry Ford's Perfect Depression Care* program was the pre-cursor to what is now called *Zero Suicide*, and its overall goal was to eliminate suicide among its members. More broadly, the aim was to redesign delivery of depression care to achieve "breakthrough improvement" in quality and safety by focusing on six aims: effectiveness, safety, patient centeredness, timeliness, efficiency, and equity among patients. The program screened and assessed each patient for suicide risk and implemented coordinated continuous follow-up care system wide (C. E. Coffey, 2006). An examination of the impact of the program found that there was a dramatic and statistically significant decrease in the rate of suicide between the baseline years, 1999 and 2000, prior to the intervention to the intervention years, 2002-2009. During this time period, the suicide rate fell by 82% (C. E. Coffey, 2006; C. E. Coffey, Coffey, & Ahmedani, 2013). Further, among HMO members who received mental health specialty services, the suicide rate decreased from 110.3/100,000 in 1999 to 47.6/100,000 in 2010 ($p<.04$) with a mean of 36.2/100,000 over the time period. Additionally, for those HMO members who accessed only general medical services as opposed to specialty mental health services, the suicide rate increased, from 2.7/100,000 to 5.6/100,000 ($p<.01$). Similarly, in the state of Michigan, rates of suicide in the general population increased over the period from 9.8/100,000 to 12.5/100,000 ($p<.001$) (M. Coffey, Coffey, & Ahmedani, 2015).

Comment [A]: From JM: I think you need to provide a little more context on Henry Ford so the readers understands in what kind of population the reductions were experienced. I assume from the end that Henry Ford is some sort of HMO, but just a little more information would help clarify this description to readers.

Comment [A]: From JH: how much?

- **Crisis intervention.** Suicide prevention hotlines are one way to provide crisis intervention. In an evaluation of the effectiveness of the *National Suicide Prevention Lifeline (NSPL*) to prevent suicide, 1,085 suicidal individuals who called the hotline completed a standard risk assessment for suicide, and 380 of those completed a follow-up assessment between 1 and 52 days (mean=13.5 days) after the initial assessment. Researchers found that over half of the initial sample were seriously considering suicide when they called, and they had a plan for their suicide. Researchers also found that among follow-up participants, there was a significant decrease in psychological pain (F=52.8, p<.001), hopelessness (F=47.8, p<.001) and intent to die (F=7.57, p<.01) between initiation of the call (time 1) to follow-up (time 3). Between time 2 (end of the call) to time 3, the effect remained for psychological pain (F=14.1, p<.001) and hopelessness (F=17.03, p<.001) but was not significant for intent to die. (Gould, Kalafat, Harrismunfakh, & Kleinman, 2007).

  In another study, this time employing a randomized controlled trial, Gould, Cross, Pisani, Munfakh, and Kleinman (2013) assessed the impact of the *Applied Suicide Intervention Skills Training (ASIST)*, a widely implemented training program that helps hotline counselors, emergency workers, and other gatekeepers to identify and connect with suicidal individuals, understand their reasoning for living and dying, and assist with safely connecting those in need to available resources. The training was evaluated across the NSPL network of hotlines over the period 2008-2009. Using data from 1,410 suicidal individuals who called 17 Lifeline centers, researchers found that compared to callers who spoke to counselors that received the usual care training, individuals who spoke with counselors without training in *ASIST* were significantly more likely to feel depressed (OR=1.31 (1.01, 1.71)), suicidal (OR=1.74 (1.39, 2.18)), more overwhelmed (OR=1.46 (1.18, 1.82), and less hopeful (1.35 (1.04, 1.77)) by the end of their call to the hotline compared to those with training in *ASIST*. Counselors trained in *ASIST* were also more skilled at keeping callers on the phone longer and establishing a connection with them. However, training in *ASIST* did not result in more comprehensive suicide risk assessments than usual care training (Gould et al., 2013).

Comment [A]: From JH: Report magnitude of decrease?

Comment [A]: This is really the best I can do. Not sure if you want this level of detail however.

Comment [A]: To be consistent with above I added some measures of association.

Intervene to Lessen Harms and Prevent Future Risk

Rationale

Individuals who have experienced mental health challenges, suicidal ideation, who have made suicide attempts or engaged in non-suicidal self-injury are at increased risk of suicide (U.S. Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Risk of suicide can also increase among those who have lost a friend, family member, co-worker, or other acquaintance to suicide (Pitman, Osborn, King, & Erlangsen, 2014). Exposure to sensationalized or uninformed reporting regarding on suicide may heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion (Etzersdorfer & Sonneck, 1998; Niederkrotenthaler & Sonneck, 2007).

Approaches

~~A broad array of a~~The four approaches included here to lesson harms and reduce future risk of suicide among those at increased risk focus on providing appropriate mental healthcare, continuity of care, caring for the bereaved, and providing safe messaging around suicide. ~~include the provision of mental health care and improved continuity of care, improving linkage to care through active post-discharge planning and follow-up that decreases barriers to ongoing therapeutic support, increasing connectedness to supportive others, addressing bereavement, and framing communications to emphasize resilience, decrease negative affect, and to prevent contagion.~~

- **Treatment for people at-risk of suicide** typically includes various forms of psychotherapy delivered by licensed providers to help individuals with mental health problems and other risk factors for suicide with problem-solving, impulsivity and emotion regulation. Treatment usually takes place in a one on one or group format between patients and clinicians in mental healthcare settings and can vary in duration from several weeks to ongoing therapy for years in some cases.

- **Treatment to prevent re-attempts.** These approaches typically include follow-up contact and use diverse modalities (e.g., home visits, mail, telephone, e-mail) to engage recent suicide attempt survivors in continued treatment to prevent re-attempts. Treatment may focus on improved coping skills, mindfulness, and other emotional regulation skills, and may include case management home visits to increase adherence to treatment and continuity of care; and one-on-one interpersonal therapy and/or group therapy. Approaches that engage and connect attempters to peers and providers are especially important because many attempters do not present to aftercare; 12%-25% reattempt within a year, and 3%-9% of attempt survivors die by suicide within 1 to 5 years of their initial attempt (Inagaki et al., 2015)

- **Postvention** approaches are implemented *after* a suicide has taken place and may include debriefing sessions, counseling, and/or bereavement support groups for surviving friends and

Comment [A]: From LLD: simplify statement and make it consistent with the other introductory statements about approaches. You may also want to take a look at the introductory statements to this section in the other TPs.

KH: edited.

Comment [A]: From LLD: Suggest fleshing this description out a bit. You may want to mention how these are typically delivered (e.g., one on one or group formats; typical number of sessions, location, etc.).

Included some of this info. I don't think there's a "typical" number of sessions, as it seems to vary across treatment settings.

family members/loved ones. These programs have not typically been evaluated for their impact on suicide or suicidal behavior but may reduce survivors' guilt, feelings of depression, and complicated grief (Szumilas & Kutcher, 2011).

- **Safe messaging following a suicide.** The manner in which information on a recent suicide is communicated to the public (e.g. school assemblies, mass media, social media) can heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion. Therefore, responsible and safe reporting may help prevent suicide and suicide contagion.

Comment [A]: From JH: add something about contagion?

KH: added

Potential Outcomes

- Reductions in mental health-related sequelae
- Increases in connectedness
- Improvements in coping skills
- Improvements in messaging following suicide
- Reductions in re-attempts
- Reductions in contagion effects related to suicide

Evidence

The evidence addressing strategies to lesson harm and prevent future risk of suicide includes the evaluation of effects of specific approaches on risk and protective factors as well as suicide-related mortality. However, because the evaluation of suicide-related mortality requires large sample sizes and extended follow-up, much of the evidence in this area primarily focuses on risk and protective factors.

- **Treatment for people at-risk of suicide**. There are a number of treatments with evidence of impact on risk and protective factors for suicide. One example is the *Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)* program. *IMPACT* aims to prevent suicide among older primary care patients by reducing suicide ideation and depression in primary care settings. It facilitates the development of a therapeutic alliance, a personalized treatment plan that includes patient preferences, as well as proactive follow-up (biweekly during an acute phase and monthly during continuation phase) by a depression care manager (Hunkeler et al., 2006). The program has been shown to significantly improve quality of life, and to reduce functional impairment, depression and suicidal ideation over 24-months of follow-up (Hunkeler et al., 2006; Unutzer et al., 2006) relative to patients who received care as usual.

Another example is *Collaborative Assessment and Management of Suicidality (CAMS)*, which is a therapeutic approach for suicide-specific assessment and treatment of patient's suicide risk. This flexible approach can be used across treatment settings and clinician theoretical orientations and involves the clinician and patient working together in an interactive assessment process to develop patient-specific treatment plans. *CAMS* sessions are collaborative and involve constant patient input about what is and is not working with the ultimate goal of enhancing the therapeutic alliance and increasing treatment motivation in the suicidal patient. *CAMS* been tested and supported in 6 correlational studies (Jobes, 2012), in a variety of inpatient and outpatient settings and in one RCT with several additional RCTs under way. *CAMS* has been associated with significant improvements in suicidal ideation, overall symptom distress, and feelings of hopelessness at 12 month follow-up among a community-based sample of suicidal outpatients. (Comtois et al., 2011).

Comment [A]: From TS: I think a word is missing – "patient input"?

Added.

Other examples include *Dialectical Behavioral Therapy (DBT)* and *Attachment-Based Family Therapy (ABFT). DBT* is a multicomponent therapy for individuals at high risk for suicide and who may struggle with impulsivity and emotional regulation. The components of *DBT* include individual therapy, group skills training, between-session telephone coaching and a therapist consultation team. In a randomized controlled trial of women with recent suicidal or self-injurious behavior, those receiving *DBT* were half as likely to make a suicide attempt at two-year follow-up than women receiving community treatment (23% vs 46%), required less hospitalization for suicide ideation, and had lower medical risk across all suicide attempts and self-injurious acts combined (Linehan et al., 2006).

ABFT is a program for adolescents aged 12-18 and is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety (Diamond et al., 2010). A randomized controlled trial of ABFT found that suicidal adolescents assigned to *ABFT* experienced significantly greater improvement in suicidal ideation over 24 weeks of follow-up than did adolescents assigned to enhanced usual care. Additionally, a significantly higher percentage of *ABFT* participants reported no suicidal ideation in the week prior to assessment at 12 weeks than did adolescents receiving enhanced usual care (69.2% vs. 34.6%) and at 24 weeks (82.1% vs. 46.2%) (Diamond et al., 2010).

- **Treatment to prevent re-attempts.** Several strategies that aim to prevent re-attempts have demonstrated impact on reducing suicidal behavior. For example, *Emergency Department Brief Intervention with Follow-up Visits* is a program that involves a one-hour discharge information session that addresses suicidal behavior, distress, risk and protective factors, alternatives to suicidal behavior, and referral options, combined with nine follow-up contacts over 18 months (at 1, 2, 4, 7, 11 weeks and 4, 6, 12, 18 months). Follow-up contacts are either conducted by phone or through home visits according to a specific time line for up to 18-months. A randomized

controlled trial that enrolled suicide attempters from eight hospital emergency departments in five culturally different countries (Brazil, India, Sri Lanka, Iran, and China)~~sites~~ found that a brief intervention combined with 9 follow-up visits over 18-months was associated with significantly fewer deaths from suicide relative to a treatment-as-usual group (0.2% versus 2.2%, respectively) (Fleischmann et al., 2008).

Another example of treatment to prevent re-attempts involves *active follow-up contact approaches* such as postcards, letters, and telephone calls intended to increase a patient's sense of connectedness with health care providers and decrease isolation. These approaches include expression of care and support and typically invite patients to reconnect with their provider. Contacts are made periodically (e.g., monthly or every few months in the first 12 months post-discharge with some programs continuing contact for two or more years). In a meta-analysis conducted by Inagaki et al. (2015), interventions to prevent repeat suicidal behavior in patients admitted to an emergency department for suicide attempt were found to reduce reattempts by approximately 17% for up to 12 months post-discharge; however, the ~~long-term~~ effects of these approaches over periods of time longer than one year on reattempts has not yet been demonstrated. Also, because the number of trials and associated sample sizes included in this meta-analysis were small, it was not possible to determine the effect of active contact and follow-up approaches on death by suicide. In a randomized controlled trial of the post-crisis suicide prevention long-term follow-up contact approach, Motto and Bostrom (2001) found that patients who refused ongoing care but who were randomized to be contacted by letter four times per year had a lower rate of suicide over two years of follow-up than did patients in the control group who received no further contact. Other studies have also shown post-crisis letters and coping cards to be protective against suicide ideation and attempts (Hassanian-Moghaddam, Sarjami, Kolahi, & Carter, 2011; Wang et al., 2016).

Finally, *Cognitive Behavior Therapy for Suicide Prevention (CBT-SP)* is an example of a therapeutic approach to prevent re-attempts. It uses a risk-reduction, relapse prevention approach that includes an analysis of proximal risk factors and stressors (e.g., relationship problems, school or work-related difficulties) leading up to and following the suicidal event; safety plan development; skill building; and psychoeducation. *CBT-SP* also has family skill modules focused on family support and communication patterns as well as improving the family's problem solving skills. A randomized controlled trial of *CBT-SP* found that 10-session outpatient cognitive therapy designed to prevent repeat suicide attempts resulted in a 50% reduction in the likelihood of a suicide reattempt among adults who had been admitted to an emergency department for a suicide attempt relative to treatment as usual (Brown et al., 2005).

Comment [A]: From JH: Unclear. According to the article, this program was evaluated in five countries. Please state the countries. Thnx.

Added.

Comment [A]: From JH: Define (follow-ups greater than 1 year)

Revised.

Comment [A]: From JH: Define

KH: Defined later in the sentence - contact 4x/yr, 2 years of follow up.

- **Postvention** programs are implemented with the goal of providing support to survivors of others' suicide to reduce their own risk of suicide. One example of a postvention program, *StandBy Response Service* (*StandBy),* provides clients with face-to-face outreach and telephone support through a professional crisis response team. Site coordinators develop customized case management plans, referring clients to other existing community services matched to their needs (Visser, Comans, & Scuffham, 2014). In a study by Visser et al. (2014), *StandBy* clients were significantly less likely to be at high risk for suicidality than a suicide bereaved comparison group who had not had contact with the *StandBy* program (48% and 64% respectively). Additionally, research suggests that active postvention approaches in which outreach to suicide survivors occurs at the scene of a suicide is associated with intake into treatment sooner, greater attendance at support group meetings, and attendance at more meetings compared to passive postvention (versus passive approaches where survivors self-refer for services) (J. Cerel & Campbell, 2008).

- **Safe messaging following a suicide.** Safe messaging after a suicide can help assure that reporting of the event is done in such a way to reduce risk to consumers of news media and other messaging who may be particularly vulnerable. One way to ensure safe messaging following a suicide is to encourage that reporters adhere to *Recommendations for Reporting on Suicide* (http://www.reportingonsuicide.org). Reports that are both inclusive of suicide prevention messages, stories of hope and resilience, risk and protective factors, and links to helping resources (e.g., hotline) and that avoid sensationalizing events or reducing suicide to one cause can help reduce the likelihood of suicide contagion. The most compelling evidence supporting the effect of *recommendations* for reporting on suicide on reduction in suicides comes from Austria. After a sharp increase in suicides on the Viennese subway, media guidelines were introduced and an interrupted time series design was used to evaluate the national impact of the guidelines on subsequent suicides. Changes in the quality and quantity of media reporting resulted in a nationwide significant reduction of 81 suicides annually (Niederkrotenthaler & Sonneck, 2007). Finally, research suggests that not only does reporting on suicide in a negative way (e.g., reporting on suicide myths and repetition) have harmful effects on suicide, but reporting on positive coping skills in the face of adversity can also demonstrate protective effects against suicide (Niederkrotenthaler et al., 2010). Reports of individual suicidal ideation not accompanied by reports of suicide or suicide attempts, along with reports describing a "mastery" of a crisis situation where adversities were overcome, associated with significant decreases in suicide rates in the time period immediately following such reports (Niederkrotenthaler et al., 2010).

Comment [A]: From TS: Don't you mean "Recommendations for Reporting on Suicide"?
Please cite:
http://afsp.org/wp-content/uploads/2016/01/recommendations.pdf

The media did not want "guidelines" and they reacted negatively to the idea of external guidelines.

KH: Edited accordingly. I didn't realize they didn't like the idea of "guidelines" - interesting.

Comment [A]: I think this is a better link.

Comment [A]: From TS: Are you sure that the 81 reduction was just on the subway system? I thought that was nationally. Please confirm.

KH: it was nationally – apologies for the oversight in the way this was written.

Comment [A]: From TS: Thomas also had a 2010 report that suggested benefits of good reporting.
http://bjp.rcpsych.org/content/bjprcpsych/197/3/234.full.pdf

KH: Added.

Sector Involvement

Public health can play an important and unique role in addressing suicide. Public health agencies, which typically place prevention at the forefront of efforts and work to create broad population-level impact, can bring critical leadership and resources to bear on this problem. For example, these agencies can serve as a convener, bringing together partners and stakeholders to plan, prioritize, and coordinate suicide prevention efforts. Public health agencies are also well positioned to collect and disseminate data, implement preventive measures, evaluate programs, and track progress. Although public health can play a leadership role in preventing suicide, the strategies and approaches outlined in this technical package cannot be accomplished by the public health sector alone. As noted in the National Strategy to Prevent Suicide, the integration and coordination of prevention activities across sectors and settings is critical for expanding the reach and impact of suicide prevention efforts.

Other sectors vital to implementing this package include, but are not limited to, education, government (local, state, and federal), social services, health services, business, labor, justice, housing, media, and organizations that comprise the civil society sector such as faith-based organizations, youth-serving organizations, foundations, and other non-governmental organizations. Collectively, these sectors can make a difference in preventing suicide by impacting the various contexts and underlying risks that contribute to suicide.

The strategies and approaches described in this technical package are summarized in Appendix A along with the relevant sectors that are well positioned to lead implementation efforts. For example, business and labor, health care insurers and providers, and government entities are in the best position to implement programs and policies that *Strengthen Economic Supports* and *Access to Mental Health Care*. These types of supports go beyond individual behavior change and require commitment and support from those sectors that can directly address some of the underlying risks and the environmental contexts that increase the risk for suicide. Public health entities can play an important role by gathering and synthesizing information to inform policy, raise awareness, and evaluate the effectiveness of various policies. Moreover, partnerships with non-governmental and community organizations can be instrumental in increasing awareness of and garnering support for policies affecting individuals and families.

The public health sector has been at the forefront of many community-based prevention efforts, working collaboratively with schools and community-based organizations, to change social norms and positively impact health behavior. Public health is well suited to take on a similar leadership role in *Promoting*

Connectedness through peer norm and community engagement activities and supporting the development, evaluation, and adoption of effective programs that *Teach Coping and Problem-Solving Skills* to prevent suicide from happening in the first place. These programs are often delivered in school and community settings, making education and non-governmental organizations vital partners in prevention.

Businesses, workplaces, and local and state government entities, on the other hand, are in the best position to establish policies and support practices that *Create Protective Environments* where people live, work, and play. Public health entities can play an important role by gathering and synthesizing information, working with other agencies within the executive branch of their state or local government in support of policy and other approaches, and evaluating the effectiveness of measures taken. In a similar fashion, public health entities can partner with schools, workplaces, and community organizations to implement and evaluate prevention programs, policies and practices geared toward creating safe, healthy, and supportive environments.

Finally, this technical package includes a number of interventions delivered in hospital, primary care, behavioral health care, and community settings designed to *Identify and Support People At-Risk* and to *Lessen Harms and Prevent Future Risk*. The intensity and activities of these interventions require the expertise of professionals who are licensed and trained to deliver critical intervention support. The health care, social services, and justice sectors can work collaboratively to support individuals at high-risk for suicide and their families. These activities also require coordination of supports across various service providers and community organizations.

Regardless of strategy, action by many sectors will be necessary for the successful implementation of this package. In this regard, all sectors can play an important and influential role in preventing suicide from happening in the first place and lessening the immediate and long-term harms of suicidal behavior by helping those in times of crisis get the services and support they need.

Monitoring and Evaluation

Comment [A]: From TS: This description seems incomplete comparted to the description of YRBS

Monitoring and evaluation are necessary components of the public health approach to prevention. It is important to have timely and reliable data to monitor the extent of the problem and to evaluate the impact of prevention efforts. Data are necessary for program implementation as planning, implementation, and assessment all rely on accurate measurement of the problem.

Surveillance data helps researchers and practitioners track changes in the burden of suicide. Surveillance systems exist at the federal, state, and local levels. It is important to assess the availability of surveillance data and data systems across these levels to identify and address gaps in the systems. CDC's National Vital Statistics System and the National Violent Death Reporting System (NVDRS) are examples of surveillance systems that provide data on deaths from suicide. NVDRS, for example, is a state-based surveillance system that combines data from death certificates, law enforcement reports, and coroner or medical examiner reports to provide detailed information on the circumstances of violent deaths, including suicide, which can assist communities in guiding prevention approaches (Blair, Fowler, Jack, & Crosby, 2016). The National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP) provides nationally representative data about all types and causes of nonfatal injuries treated in U.S. hospital emergency departments, and can be used to assess national rates of, and trends in, self-harm injuries by cause (e.g., falls, poisoning, etc.), age, race/ethnicity, sex, disposition (where the injured person goes when released from the Emergency Department).

In addition to information on deaths and nonfatal injuries, there are also surveillance systems that provide national, state, and some local estimates of suicidal behavior. The Youth Risk Behavior Surveillance System (YRBSS) collects information from a nationally representative sample of 9-12 grade students and is a key resource in monitoring health-risk behaviors among youth, including whether youth have seriously considered attempting suicide, attempted suicide, made a plan, or required treatment by a doctor or nurse for a suicide attempt that resulted in an injury, poisoning, or overdose (Brener et al., 2013). The YRBSS data are obtained from a national school-based survey conducted by CDC as well as from state, territorial, tribal, and large urban school district surveys conducted by education and health agencies. The National Survey on Drug Use and Health (NSDUH) is an annual survey of the civilian, non-institutionalized population aged 12 years and older. NSDUH provides both national and state-level estimates of substance use, including alcohol, tobacco, illicit drugs, and non-medical use of prescription drugs; and mental health, including past year mental illness, co-occurring illnesses, service utilization, along with suicide ideation, suicide plans, and suicide attempts. NSDUH is a key resource to track trends in suicide-related risk factors in the population and to help identify groups at increased risk.

It is also important at all levels (local, state, and federal) to address gaps in responses, track progress of prevention efforts and evaluate the impact of those efforts, including the impact of this technical package. Evaluation data, produced through program implementation and monitoring, is essential to provide information on what does and does not work to reduce rates of suicide and its associated risk

and protective factors. Theories of change and logic models that identify short, intermediate, and long-term outcomes are an important part of program evaluation.

The evidence-base for suicide prevention has advanced greatly over the last few decades. However, additional research is needed to understand the impact of programs, policies, and practices on suicide (and suicide attempts, at a minimum), as opposed to merely examining their effectiveness on risk factors ~~associated with suicide~~. More research is also needed to examine the effectiveness of upstream (before risk occurs) and community-level strategies to prevent suicide at the population level. Lastly, it will be important for researchers to test the effectiveness of combinations of the strategies and approaches included in this package. Most existing evaluations focus on approaches implemented in isolation, but there is potential to understand the synergistic effects within a comprehensive prevention approach. ~~Additional research is needed to understand the extent to which combinations of strategies and approaches result in greater reductions in suicide than individual programs, practices, or policies.~~

Conclusion

Suicide is a serious public health problem whose rates have been on the rise for more than a decade and whose costs stretch well into the billions of dollars each year. While suicide is a rare outcome statistically, its human impact has a ripple effect that is far-reaching. Each of us likely interacts with suicide survivors, those with lived experience, and those with thoughts of suicide, on a daily basis--at home, at work, and in our communities. Suicide and suicide attempts are therefore public health issues of societal concern. Fortunately, like many public health problems, suicide is preventable, and fortunately more is being done to prevent suicide than ever before, as evidenced by the work of the National Action Alliance for Suicide Prevention, the release of the first world report on suicide, and more timely surveillance data, to name just a few examples. Unfortunately and unlike most other public health problems, suicide prevention must still overcome ~~struggles against~~the: stigma, shame, and secrecy related to help-seeking, mental illness, being a survivor, or someone with lived experience; misplaced fear ~~of~~ related to asking someone about their risk of suicide (versus the fear and consequence of *not* asking), ~~and~~ fear of taking up strategies known to be effective but perhaps unpopular; misinformation about suicide preventability, misplaced emphasis by the media and others on sensational aspects of suicide, and disproportionate funding given its public health burden. ~~Suicide also struggles against the right degree of awareness where too much information, for example by well-meaning reporters and others, may actually do harm.~~

In an effort to continue pushing the field and society further towards prevention, this technical package includes strategies and approaches that ideally would be used in a comprehensive fashion, in combination--in a multi-level, multi-sectoral way. This technical package includes strategies and approaches targeting upstream prevention (e.g., social emotional learning for children and youth), as well as strategies focused more downstream (e.g., cognitive behavioral treatment to prevent re-

Comment [A]: From TS: Should this be programs, policies, and practices to be consistent?

Comment [A]: From JH: including attempts?

Comment [A]: From JH: redundant with prior sentence.

Comment [A]: From TS: I found this somewhat awkward. The idea of suicide struggling seemed off and the point is not entirely clear. I think you can be more specific and reference an earlier point in the media recommendations section.

Comment [A]: From JH: Upstream/downstream is jargon.

Comment [A]: I prefer to keep this language in if it's ok. The e.g. is meant to help define the terms and it's been mentioned previously and defined. It's also a continued topic of discussion in the field that we need to focus more upstream. Iterating and re-iterating it is good I think. And lastly, there's a lot of jargon and terms in here that we'd also have to get rid of if we're honest about the use of jargon and reading level!

attempts). It includes ~~universal, selective, and indicated strategies, or~~ strategies that range from a focus on the whole population regardless of risk to strategies designed to support people at highest risk. Importantly, this technical package extends the bounds of the typical prevention strategies to consider approaches ~~at the outer levels of the social ecology,~~ that go beyond individual behavior change to better address risk factors impacting communities and populations more broadly e.g., policies to stabilize housing and community engagement initiatives.

While the evidence base continues to emerge, the collection of programs, policies, and practices laid out here are available for implementation now. And in keeping with good public health practice, the intent is that monitoring and evaluation will play a key role in that implementation. Moreover, as new evidence becomes available, this technical package can be refined to reflect the current state of the science.

In closing, and in keeping with a message of resilience as spoken by those with lived experience, 'hope, help, and healing is possible.'

Comment [A]: From TS: I think you can drop this and just use the more descriptive text. You don't need both. You could describe this as a range.

Comment [A]: From JM: Yes this is jargon, so the e.g., helps, but you might want to figure out a way to say this without referring to the outer levels of the social ecology.

Comment [A]: This sets you up for people to say oh yeah what about… AI/AN, transgendered people, prisoners etc.

Comment [A]: I'm not exactly clear on how to take this comment and subsequently how to address it. Open to ideas.

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Appendix A: Summary of Strategies and Approaches to Prevent Suicide

Strategy	Approach/Program, Practice or Policy	Best Available Evidence			Lead Sectors[1]
		Suicide	Suicide Attempts or Ideation	Other Risk/Protective Factors for Suicide	
Strengthen economic supports	**Strengthen household financial security**				Government (local, state, Federal) Business/labor
	Unemployment benefit programs	✓			
	Other income supports	✓			
	Housing stabilization policies				Government (local, state, Federal)
	The National Neighborhood Stabilization Program			✓	
Strengthen access to mental health care	**Coverage of mental health conditions in health insurance policies**				Health care Government (state, Federal)
	Mental Health Parity Laws	✓		✓	
Establish protective environments	**Reducing access to lethal means among persons at-risk**				Government (local, state) Public Health
	Intervening at suicide hot spots	✓			
	Safe storage practices		✓	✓	
	Organizational policies and culture				Business/Labor Government (local, state, Federal)
	Together for Life	✓			
	US Air Force Suicide Prevention Program	✓		✓	

		Best Available Evidence			
	Community-based policies to reduce excessive alcohol use				Government (local, state) Business/labor
	Alcohol outlet density	✓		✓	
Promote connectedness	**Peer norm approaches**				Public Health Education
	Sources of Strength			✓	
	Community-engagement activities				Public Health Government (local)
	Greening vacant urban spaces			✓	
Teach coping and problem-solving skills	**Social emotional learning**				Public Health Education
	Youth Aware of Mental Health Program		✓		
	Signs of Suicide		✓	✓	
	Good Behavior Game		✓	✓	
	Parenting skill and family relationship approaches				Public Health Education
	The Incredible Years			✓	
	Strengthening Families 10-14			✓	
Identify and	**Gatekeeper training**				Public Health Healthcare
	Mental Health First Aid			✓	
	Screening combined with care management				Healthcare

		Best Available Evidence			
support people at-risk	*Henry Ford Perfect Depression Care (Precursor to Zero Suicide)*	✓		✓	Social Services
	Crisis Intervention				Public Health
	National Suicide Prevention Lifeline		✓	✓	Social Services
	Applied Suicide Intervention Skills Training		✓	✓	
Intervene to lessen harms and prevent future risk	**Treatment for people at risk of suicide**				Healthcare
	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)		✓	✓	Social Services Justice
	Collaborative Assessment and Management of Suicidality (CAMS)		✓	✓	
	Dialectical Behavioral Therapy		✓	✓	
	Attachment-Based Family Therapy		✓		
	Treatment to prevent re-attempts				Healthcare
	ED Brief Intervention with Follow-up Visits	✓			Social Services
	Active follow-up contact approaches	✓	✓		
	CBT for Suicide Prevention				
	Postvention				Healthcare

		Best Available Evidence			
	StandBy Response Service		✓		
	Safe messaging following a suicide				Public Health Media
	Media Guidelines	✓			

[1]This column refers to the lead sectors well positioned to bring leadership and resources to implementation efforts. For each strategy, there are many other sectors such as non-governmental organizations that are instrumental to prevention planning and implementing the specific programmatic activities.

From: LiKamWa, Wendy (CDC/CCEHIP/NCIPC)
Sent: 5 Feb 2016 22:49:06 +0000
To: McIntosh, Wendy LiKamWa (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Conversation with LiKamWa, Wendy (CDC/CCEHIP/NCIPC)

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 9:37 AM:
aww, el jefe was really disappointed that HH was cancelled yesterday

"Wendy - Sorry this didn't work out. I'm curious how many people RSVP'ed "yes". I was planning to attend, but didn't have a chance to respond to your email. Let's reschedule soon.

Thanks. Jeff "

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:38 AM:
that's too bad. i think people will always cancel at the last min so might be better to just keep the time and not cancel or you might have to reschedule lots of times. Just make sure you have someone you know who is going besides el jefe!!!

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 9:39 AM:
well, that was the point. no one was going
I told him that after I sent the email yesterday morning, no one responded that they were definitely planning to attend, but I received emails from 17 people who said they weren't going to make it. And 2 maybes.

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 10:16 AM:
haha, guess who was the first person to RSVP to the new HH invite

Stone, Deborah (CDC/ONDIEH/NCIPC) 10:16 AM:
me?
haha
el jefe

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 10:18 AM:
yup, el jefe

Stone, Deborah (CDC/ONDIEH/NCIPC) 10:18 AM:
poor guy. he does try hard and mean well.

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 10:20 AM:
yeah, i know
it's like he desperately wants to be liked
but he drives everyone crazy with his micro-management

Stone, Deborah (CDC/ONDIEH/NCIPC) 10:21 AM:
exactly. do you think i should tell him? LOL!

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 10:21 AM:
haha, go right ahead. maybe wait until we get the $30M for SP ;)

Stone, Deborah (CDC/ONDIEH/NCIPC) 10:21 AM:
haha!
good point!
btw, our proposal is with CDC/OD now!

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 10:22 AM:
I sent you a text about my plans for next week
You'll be ok by yourself on the call with Yeates and Kim, right?

Stone, Deborah (CDC/ONDIEH/NCIPC) 10:22 AM:
oh ok. for some reason my phone is nowhere to be found. hold on..
ugh. yes, will be ok with yeates and kim. hope yeates is in a better mood this time. he seemed a bit cranky last time.

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 10:24 AM:
well, kim wasn't on the last call, right?
or am i misremembering?
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 10:39 AM:
ok, I need to buckle down and finish revising this MMWR
would you have a minute to look for any articles on females in the protective service?
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 2:56 PM:
haha, one of the police articles i saw listed "access to firearms," and I was like, that would raise a few red flags!
Stone, Deborah (CDC/ONDIEH/NCIPC) 2:56 PM:
it's ok. that's fair territory!
that's a big reason why their rates are high
we aren't saying take away their guns!
at least not explicitly!
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 2:57 PM:
actually, the tiesman et al article (i.e., NIOSH) talks about firearms and access to firearms a lot
Stone, Deborah (CDC/ONDIEH/NCIPC) 2:59 PM:
yeah, it's more of an issue if we are advocating for gun control. it's a fact that access is a risk factor.
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:00 PM:
still, "lethal means" is probably less likely to create issues compared to using the F-word
Stone, Deborah (CDC/ONDIEH/NCIPC) 3:00 PM:
very true.
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:08 PM:
grr, none of the references we included talk about reasons for management occs to have higher risk
i mean, i can speculate and make up my own reasons
but in the colorado paper, the highest number of suicides was in management, and they didn't talk about it at all
Stone, Deborah (CDC/ONDIEH/NCIPC) 3:14 PM:
see if you can find anything in the database about job stress or job strain. i'm pretty sure i've seen that.
you can search the enl for job stress or job strain and see if articles pop up.
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:15 PM:
that's not what i meant
I mean we're at our max of 10 references
and none of our current references talk about reasons for management occupations having higher suicide rates
Stone, Deborah (CDC/ONDIEH/NCIPC) 3:15 PM:
oh sorry. i'm unclear why we can only have 10 esp if we need 11. i'd make a note to jaqueline.
i'm sure they can make an exception
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:21 PM:
i can't find a good article quickly
Stone, Deborah (CDC/ONDIEH/NCIPC) 3:22 PM:
i can look if you want.
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:22 PM:
I'm just going to send it as is, and then if she asks for more information, we can add another reference
Stone, Deborah (CDC/ONDIEH/NCIPC) 3:22 PM:
ok
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:26 PM:
although, this sounds kinda stupid: "Of note, while management occupations had the tenth highest rate of suicide, they accounted for the second largest percentage of suicide deaths in the sample; therefore, it is important to target prevention strategies to managers as

well. Suicide prevention strategies targeting these occupation subgroups should take into account these specific risk factors "

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:38 PM:

help? the rest of the team has deserted me

Stone, Deborah (CDC/ONDIEH/NCIPC) 3:40 PM:

Of note, while management occupations had the tenth highest rate of suicide, they accounted for the second largest percentage of suicide deaths, OVERALL, in the sample; therefore, it is important to target prevention strategies to managers as well. "

i'd delete the last sentence.

suicide prevention strategies targeting these..

and maybe delete 'in the sample '

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:40 PM:

okies, that works!

thank you!!

Stone, Deborah (CDC/ONDIEH/NCIPC) 3:41 PM:

;)

i won't dessert you! or is it desert?

haha

(^)

hehe

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:42 PM:

dessert is that yummy sweet stuff after a meal. desert is the dry place filled with sand and scorpions, and is also a verb that means to abandon :P

Stone, Deborah (CDC/ONDIEH/NCIPC) 3:43 PM:

haha! awesome! oh and speaking of scorpions--that was so dumb for el jefe to mention that to khyia! nobody knew what he was talking about!

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:43 PM:

i know!

well, i did

Stone, Deborah (CDC/ONDIEH/NCIPC) 3:44 PM:

well you and brad and maybe one other person...

still...poor khyia was like um yeah..

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:44 PM:

hahaha

Stone, Deborah (CDC/ONDIEH/NCIPC) 3:44 PM:

or um...no

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:44 PM:

"moving right along..."

Stone, Deborah (CDC/ONDIEH/NCIPC) 3:44 PM:

haha!

did you read that cdc connects story!?

about that woman who used to be in SB?

omg...if i were her i'd probably have done everything wrong (won't give it away if you didn't read)

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 3:52 PM:

do you have a minute to look at what i just sent, and make sure I addressed everything, and didn't leave internal comments in there, etc.?

and what should I say in my email response to doug (the lead MMWR editor)? he asked that i send the revisions to him, not jacqueline

Stone, Deborah (CDC/ONDIEH/NCIPC) 3:55 PM:

ok. will review now.

Stone, Deborah (CDC/ONDIEH/NCIPC) 3:59 PM:
why is there a parenthesis that says (reference) after we talk about the census? Is a reference needed there?
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:00 PM:
what page are you on
oh i see
that's language that NIOSH added, i think
i think it means that the codes are the reference
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:02 PM:
also, i'd respond to her second comment in the discussion section about rates and numbers of people...something like we addressed the issue below...
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:02 PM:
although i could have completely misinterpreted, but no one else has picked up on it
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:02 PM:
ok. just leave it for now.
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:03 PM:
ok
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:03 PM:
where it says, "The proportion of suicides for males to females was similar to the national proportion in 2012, which was 78.3% and 21.7%, respectively. " I'd add the wisqars ref (1)

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:03 PM:
i mean, ok to responding to her comment
good catch
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:05 PM:
that's all i got!
looks good!
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:07 PM:
thanks
ok, i'm guessing bradford isn't going to weigh in
I already talked to aimee earlier
she's on her flex day, so she said she didn't need to see it unless i wanted her to
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:08 PM:
yeah, he's fine.
i mean go ahead without him though he did just send me an email on something else so he may be working on it now.
maybe email or im him and say you are going to send now unless he wants you to wait.
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:09 PM:
haha, I just IMed him
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:10 PM:
cool
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:10 PM:
he says he trusts us all and to please send
ok, how about this for an email response, "Dear Doug,
Thank you. We have made the requested revisions.
haha, i can't think of anything else to say
I was going to add, "we'd be happy to discuss any remaining questions with jacqueline," but then it sounds like we'd rather be communicating with her directly instead of him
crap, sorry
didn't mean to call
i think "ctrl + enter" starts a phone call?

Stone, Deborah (CDC/ONDIEH/NCIPC) 4:15 PM:
Ok, sorry, was getting a snack. lol.
and i didn't see that you called.
um...ok...
Dear Dougie,
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:16 PM:
love, wendy
wendie
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:16 PM:
hahah!
wendi
hah!
Dear Dougie,
Please find the attached revised draft attached per your request. The research team has replied to all of Jaqueline's questions/comments in track changes. Please let me know if you have any further concerns."
oops
don't say attached twice!
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:18 PM:
hahaha
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:18 PM:
that would be funny
Oh and you can always add that you appreciate the feedback.
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:18 PM:
and i probably want to spell jacqueline correctly
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:18 PM:
that's a lie but they like it
oh and yes, spell all names correctly!
just call her jackie
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:19 PM:
yes, i'm sure they'll all love that
ok, i like what you said
not sure if "please let me know if you have any further concerns" is the best thing to include
he already said that the report will then go back to the editor for another review
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:20 PM:
oh ok
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:21 PM:
maybe just keep it short and sweet, and say, thanks, wendy
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:22 PM:
yep that's fine.
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:22 PM:
just one more workday and one more hour until vacay!
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:22 PM:
woo hoo!
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:24 PM:
haha he's out of the office until monday
Stone, Deborah (CDC/ONDIEH/NCIPC) 4:26 PM:
funny. figures!
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 4:49 PM:
any plans for the weekend?
Stone, Deborah (CDC/ONDIEH/NCIPC) 5:05 PM:
sorry. i'm working on something that is annoying me so need to figure it out!

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:05 PM:
no worries
Stone, Deborah (CDC/ONDIEH/NCIPC) 5:31 PM:
ok. finished! was working on a revised codebook for a new nvdrs paper i may have told you about on train suicides. amanda is heading it up and brad and kristin and i are working on it with doryn from action alliance, jerry reed, and a guy from dept of trans.
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:32 PM:
yeah
cool
don't want to hear the gory details though!
Stone, Deborah (CDC/ONDIEH/NCIPC) 5:32 PM:
right
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:32 PM:
(tmi)
Stone, Deborah (CDC/ONDIEH/NCIPC) 5:32 PM:
haha!
that's so funny!
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:32 PM:
:&&
Stone, Deborah (CDC/ONDIEH/NCIPC) 5:33 PM:
aww...don't puke.
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:33 PM:
i will if you tell me about the train videos!
Stone, Deborah (CDC/ONDIEH/NCIPC) 5:34 PM:
yeah i'm not into watching those!
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:34 PM:
that's cool that amanda is going to AAS
natalie and brad and aimee aren't going
Stone, Deborah (CDC/ONDIEH/NCIPC) 5:35 PM:
oh. how did you find out?
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:35 PM:
kristin sent out that email earlier
and i had asked natalie and brad and aimee separately in the past few weeks
Stone, Deborah (CDC/ONDIEH/NCIPC) 5:35 PM:
oh didn't realize that's what it said.
i feel bad for brad. i know he really wanted to go. i wonder why he's not going.
because of travel issues?
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:36 PM:
yep
and he was mad that they wouldn't let aimee go on one of the YVPC site visits
Stone, Deborah (CDC/ONDIEH/NCIPC) 5:36 PM:
i feel like there should be a way to have him go
that's too bad :(
so you got the go ahead to go right?
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:37 PM:
i haven't done my travel request yet
but no one has told me i can't go
Stone, Deborah (CDC/ONDIEH/NCIPC) 5:37 PM:
ok
LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:40 PM:
if i can't go you'll have to present for me!
i agree that brad should be allowed to go

Stone, Deborah (CDC/ONDIEH/NCIPC) 5:43 PM:
i just wrote kendell and jeff an email advocating for brad and aimee but especially brad. i feel like he works so hard but gets no recognition or reward. and he's really excited by all the suicide prev stuff but can hardly participate in anything.
i should have said some of that in my email! oh well. i think i got my point across.

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:43 PM:
yeah, poor guy
oh boy, what did you write?

Stone, Deborah (CDC/ONDIEH/NCIPC) 5:44 PM:
well i said that i have two site visits that were in my travel projections but that might not take place until next fiscal year (the RSV is in April!) and i asked if aimee and brad could use those slots for AAS. and i said what a great champion brad is and that our partners would like to see him etc..
i also mentioned we may get two free registrations like we did last year if we have a table there

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:45 PM:
were you site visits for this quarter?
*your

Stone, Deborah (CDC/ONDIEH/NCIPC) 5:45 PM:
no i think quarter 4

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:45 PM:
oh, are we doing that this year?
ok, i seem to remember that they were trying to encourage people to take their trips later in the year if possible, but I'm not really sure how it works

Stone, Deborah (CDC/ONDIEH/NCIPC) 5:46 PM:
yeah i don't know how it works either but i figured i'd try.
can't really hurt. i hope! ha!

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:47 PM:
let me know what they say!

Stone, Deborah (CDC/ONDIEH/NCIPC) 5:47 PM:
ok. i'm going to get going. i hope you have a good weekend! i'm having brunch with michele on sunday and going to a superbowl party.

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:47 PM:
promise jeff that you'll go to the next happy hour, maybe that will help ;)

Stone, Deborah (CDC/ONDIEH/NCIPC) 5:47 PM:
oh yeah, that's a good idea! haha!

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:47 PM:
have a good weekend too!

Stone, Deborah (CDC/ONDIEH/NCIPC) 5:48 PM:
thanks!

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:48 PM:
today's my 8 hour day, so i'm signing off too

Stone, Deborah (CDC/ONDIEH/NCIPC) 5:48 PM:
(car)

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:48 PM:
i'll be teleworking on monday
(ninja)

Stone, Deborah (CDC/ONDIEH/NCIPC) 5:48 PM:
ok. me too
ha!

LiKamWa, Wendy (CDC/CCEHIP/NCIPC) 5:48 PM:
byeee

Stone, Deborah (CDC/ONDIEH/NCIPC) 5:48 PM:
i thought that car was going to do something...bye!

(bike)

From: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC)
Sent: 30 Jan 2017 12:13:23 -0500
To: Mercy, James (CDC/ONDIEH/NCIPC);Young, Joni (CDC/ONDIEH/NCIPC);Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Herbst, Jeffrey (CDC/ONDIEH/NCIPC);Massetti, Greta M. (CDC/ONDIEH/NCCDPHP);Payne, Gayle H. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Dorigo, Leslie (CDC/ONDIEH/NCIPC);Lenard, Courtney (CDC/ONDIEH/NCIPC)
Subject: DVP Media Report

Media Coverage

BULLYING

Jan. 23, 2017 **"Special Needs Parent Hopeful First Lady Melania Trump Will Help Curb Bullying"**

- **Publication/Outlet:** *Parent Herald*(UVM: 2.2M*)
- "First Lady Melania Trump has talked about setting an anti-bullying campaign when her husband was running for U.S. president. A special needs parent is hoping now that she has an important role in the White House, Trump will make good on her word for the sake of the parent's children with autism and other families."

GUN VIOLENCE

Jan. 20, 2017 **"Congress Gutted Researchers' Ability to Study Gun Violence. Now They're Fighting Back"**

- **Publication/Outlet:** *Mother Jones* (UVM: 12.9M*)
- "On November 14, six days after Donald Trump won the presidential election, more than 80 researchers from 42 schools of public health gathered for a closed-door meeting at the Boston University School of Public Health. Their agenda: how to get around the federal government's de facto ban on researching the health impact of gun violence and get it done anyway."

"Public Health Advocates Push Gun Safety Over Gun Control"

- **Publication/Outlet:** WGCU - Fort Meyers, Fla. (UVM: 33.8K*)
- "Members of the public health community are calling for action on gun violence by shifting the conversation away from gun control. The group is focusing on gun safety in an effort to find common ground among gun rights activists and those looking for reform... In 1996, Congress added language to a bill that said funding for the Centers for Disease Control and Prevention to research injury prevention could not be used to promote gun control. Congress later added the same language to bills funding the National Institutes of Health."

Jan. 23, 2017 **"Diversify Washington in More Ways Than One: Scientists Must Become More Involved in Political Processes"**

- **Publication/Outlet:** *Salon*(UVM: 23.4M*)
- "Through 314 Action, we also advocate an end to the ban on research by the CDC on gun violence. The Dickey Amendment, passed in 1996 as a result of pressure from the powerful NRA lobby, prohibited funds made available for injury prevention and control at the Centers for Disease

Control and Prevention from being used to advocate or promote gun control. The effects of this amendment have reduced CDC's funding for firearm research by 96 percent, leaving meager resources for any researcher looking to investigate the epidemic of gun violence. As we enter a new year and a new administration, 314 Action will seek to not only abolish this amendment, but also to promote a common sense, data-driven approach to solving gun violence."

Jan. 24, 2017 **"Outside Police Agencies to Help Wilmington Stop Crime"**

- **Publication/Outlet:** DelawareOnline.com(UVM: 1.3M*)
- "Wilmington Mayor Mike Purzycki has called upon outside law enforcement agencies to help put an end to the spike in city crime that has led to 18 shootings this year, eight of which were fatal. The CDC identified the lack of intervention among youth at pivotal moments in their lifetimes as a cause of the violence cycle."

"American Carnage' Is Real"

- **Publication/Outlets:** *Bloomberg*, "Bloomberg View" blog, *Reading Eagle*, *Chicago Tribune*, and *Providence Business Journal* (Total UVM: 117.1M*)
- "You've heard about the "American carnage." But how bad is it out there, really? Pretty horrible, actually. I am referring of course to what was probably the most memorable phrase in President Donald Trump's inaugural address."

"Beyond Gun Violence: NC Churches Join Community for Preach-In Event"

- **Publication/Outlet:** *Public News Service* and *The Charlotte Post* (Total UVM: 66.7K*)
- "Coming on the heels of the millions who participated in the Women's March on Washington and sister events, this weekend will bring another opportunity for civic engagement. Religious and community organizations are holding a preach-in event to educate people of faith on gun control and how it is supported by the teachings of their religion. The Reverend Richard Edens is one of the pastors at the United Church of Chapel Hill, the host site of Beyond Gun Violence Conference."

Jan. 25, 2017 **"Chapel Hill-Carrboro churches to talk gun violence this weekend"**

- **Publication/Outlet:** *The News & Observer*(UVM: 4.3M*)
- "We live in a nation with more than 300 million guns in circulation. We recoil at shootings in Sandy Hook or Virginia Tech and jointly lament this should not happen, but every week 30 to 35 children and young people die while another 180 are injured. Every week. It is time to pay attention."

"An Unusual Anti-Suicide Partnership Targeting Gun Shops Is Ramping Up"

- **Publication/Outlet:** *New York Magazine*(UVM: 25.2M*)
- "You probably wouldn't expect a delegation from the American Foundation for Suicide Prevention to show up to the largest annual trade event for firearms sellers. And yet that's what happened at the 2017 SHOT Show, which was held last week in Las Vegas. As Maura Ewing writes in the Trace, the delegation, perhaps a bit out-of-place-seeming "among the rows of retailers hawking the latest models of firearms and tactical gear ... had come to promote a unique partnership with the show's organizers on a nationwide suicide prevention program with the ambitious goal of

stopping nearly 10,000 deaths in the next decade."

"Obama CDC Study: Silencers Best Option for Noise Reduction at Gun Ranges"

- **Publication/Outlet:** TheTruthAboutGuns.com(UVM: 2.0M*)
- "With the introduction of the Hearing Protection Act, Congress is closer than ever to removing silencers from the purview of the National Firearms Act and ensuring that every American gun owner can easily make their firearm much quieter. Suppressed firearms are not only more enjoyable to shoot, but, according to a report by the Obama administration CDC's report on noise and lead at outdoor firing ranges, they're the only effective way to reduce the harmful noise levels."

Jan. 26, 2017 "Gun Rights Activists Sue Over Massachusetts Firearms Laws"

- **Publication/Outlet:** CNBC(UVM: 53.7M*)
- "Gun rights activists aided by the National Rifle Association are suing Massachusetts over its firearms laws, saying the state's assault weapons ban is preventing law-abiding residents from buying and possessing some of the most popular rifles in the country, as well as most standard-capacity magazines."

SEXUAL VIOLENCE

Jan. 21, 2017 "How Will President Trump Handle Violence Against Women in the US?"

- **Publication/Outlet:** *The Hill*(UVM: 40.9*)
- "This week, The Hill reported that the incoming Trump administration is looking to dramatically reduce federal spending. Of these spending cuts, funding for Violence Against Women Act (VAWA) grants was highlighted to be on the chopping block. This action is a grave mistake — it will likely put the lives of those experiencing domestic violence in danger because they will have fewer resources to escape."

Jan. 24, 2017 "Sexual Assault in the Time of Trump"

- **Publication/Outlet:** *Al Jazeera*(UVM: 18.3M*)
- "Affirmative consent, for those who don't know, is the idea that if you don't consent at every stage of a sexual encounter, it's rape. That means asking for every kiss and asking for every boob squeeze. It's almost as if feminists want everyone to remain celibate." These words were spoken last autumn to a packed auditorium of students at Auburn University in Alabama during a speech called How Feminism Hurts Women by Milo Yiannopoulos."

Jan. 25, 2017 "Anti-Domestic Violence Groups Concerned About Threatened Budget Cuts"

- **Publication/Outlet:** *Metro*(UVM: 773.8K*)
- "Police can respond to a variety of calls, but according to Milton Police Chief John King, the most common violent crime his department deals with is domestic violence. King is pretty confident it's a common call in most communities. In Massachusetts, nearly one in three women and one in five men have experienced physical violence, rape or stalking by an intimate partner, according to a Centers for Disease Control and Prevention survey — and those numbers are likely to be underreported, King said."

SUICIDE

Jan. 23, 2017 "Mind Your Mental Health"

- **Publication/Outlet:** "The Green Sheet" blog(UVM: 27.7K*)
- "Jokingly, my closest friends refer to me as "bipolar" because my mood is

seemingly always on a roller coaster ride of feeling on top of the world one minute, and then feeling as if the world is coming to an end the next. But these emotional swings are mainly due to the fact that I am financially and psychologically invested in my merchant account and merchant cash advance deals. 'Among the professions with suicide rates 1.5 times or more than the rest of the population are doctors, dentists, veterinarians, financial workers, lawyers, and engineers, according to the CDC National Occupational Mortality Surveillance Database.'"

Jan. 25, 2017 **"Gun Stores Hear a Bold Pitch at Top Firearms Trade Show: Suicide Prevention"**

- **Publication/Outlet:** *The Trace*(UVM: 248.2K*)
- "New offerings abounded at the 2017 SHOT Show, the industry's largest annual trade event, hosted last week by the National Shooting Sports Foundation in Las Vegas. But among the rows of retailers hawking the latest models of firearms and tactical gear, there was one surprising addition to this year's convention: a delegation from the American Foundation for Suicide Prevention. They had come to promote a unique partnership with the show's organizers on a nationwide suicide prevention program with the ambitious goal of stopping nearly 10,000 deaths in the next decade."

Jan. 26, 2017 **"Suicide Rates in the United States Increasing, Black Youth Hit Hardest"**

- **Publication/Outlet:** *Rolling Out*(UVM: 777.3K*)
- "Recent events in the news have exposed the hidden tragedy of suicide in America. Most recently, Nakia Venant, 14, of Miami Gardens, Florida was found hanging, Sunday, Jan. 23. She posted her final goodbye on Facebook Live. Nearly a month ago, a Georgia teen committed suicide on Facebook. On December 30, Katelyn Nicole Davis filmed her death by hanging from a tree in front of her Cedartown, Georgia home, reports say. In a video taken prior to her suicide, Davis alleged she had been physically and sexually abused by her stepfather. In Los Angeles, actor Frederick Jay Bowdy, 33, used Facebook Live to show his suicide to horrified family and friends. These well-publicized cases echo recent CDC findings that in 2016 the suicide rate in America reached a 30-year high. The CDC study titled "Increase in Suicide in the United States, 1999–2014" also found a continued increase in suicide rates for young Black males."

MULTIPLE TOPICS (Bullying, Sexual Violence, and Suicide)

Jan. 25, 2017 **"Candidates Talk Money, Mental Health, Start Times"**

- **Publication/Outlet:** *The Los Alamos Monitor*(UVM: 45.0K*)
- "Candidates running for seats on the Los Alamos School Board shared their views with the public Wednesday night during a forum organized by the League of Women Voters of Los Alamos... A recent Centers For Disease Control Survey revealed that Los Alamos youth rank above the 9.2 percent state average when it comes to sexual dating violence, suicide ideation and bullying."

* Total unique visits per month of publication's website (within one month prior to date reported)

From: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC)
Sent: 24 Feb 2017 15:05:43 -0500
To: Mercy, James (CDC/ONDIEH/NCIPC);Young, Joni (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Herbst, Jeffrey (CDC/ONDIEH/NCIPC);Payne, Gayle H. (CDC/ONDIEH/NCIPC);Massetti, Greta M. (CDC/ONDIEH/NCCDPHP);Crosby, Alexander (CDC/ONDIEH/NCIPC)
Subject: DVP Weekly Media Report

Summary

The national media covered a variety of violence-related topics with CDC mentions during the week of February 17-23.
The release of a study published in the *Journal of the American Medical Association* (JAMA), which found conducted found that suicide rates for LGBTQ teens have gone down 7 percent after the legalization of same-sex marriage, resulted in a predominant focus on teen suicide.

Media Coverage

CHILD ABUSE & NEGLECT

Feb. 17, 2017 **"Developing Resilience in Children"**

- **Publication:** *Centre Daily Times* (UVM: 652.8K*)
- "How can we impact the troubling ubiquitous human issues that characterize our society, or at least know to process the daily bombardment? From children being bullied in schools because of ethnic or social status, to increased heroin abuse because of post-traumatic stress syndrome, to increased levels of adolescent depression and suicide due to increased stressors, to increased incidences of sexual assault and cutting on college campuses, to record levels of being overweight and obesity, just to name a few, I think we can agree that something is not quite right in our modern society. The statistics from recent studies are alarming and have reached crisis levels. A 2016 study published in the Journal of Abnormal Psychology found that 83 percent of participants experienced depression, anxiety or other mental health disorder. The study was conducted over the lifetimes of 988 individuals, with a total of 13 assessments taking place between their birth and when they hit age 38. A recent American Academy of Pediatrics study found a significant increase in major depressive episodes over the past 10 years, especially among adolescent girls and young adult women."

Feb. 20, 2017 **"Effects of Adverse Childhood Experiences Focus of Summit"**

- **Publication:** *The News Star*(UVM: 404.7K*)
- "A Wednesday summit and documentary screening held at the University of Louisiana Monroe will focus on adverse childhood experiences and the long-term ramifications these experiences can have on physical and mental wellbeing. An ongoing study between the Centers for Disease Control and Prevention and the Kaiser Permanente health system launched in 1998 and has tracked the number of ACEs each of the 17,000 respondents experienced and their responses on subsequent mental and physical evaluations."

GUN VIOLENCE

Feb. 17, 2017

"Court tosses Florida 'Docs vs. Glocks' Law"

- **Publication:** UPI.com (UVM: 8.3M*)
- "A federal appeals court tossed out a Florida law restricting doctors from discussing guns and gun safety with their patients, on grounds that such restrictions are a violation of the First Amendment."

"American Council on Science and Health"

- **Publication:** *American Council on Science and Health* (UVM: 377.0K*)
- "A recent ruling by the 11th U.S. Circuit Court of Appeals in Atlanta, Georgia, found the Firearm Owners Privacy Act (FOPA)— enacted in 2011 in Florida— impeded the First Amendment free speech rights of medical professionals. The law sought to preserve Second Amendment rights but thought forbidding physicians to discuss gun ownership with patients was the way to do so. Fines and censure by the state medical board were threatened if doctors were found to be in violation. Ambiguous language didn't help."

"NRA-Backed Law Limiting Doctors' Gun Speech Struck Down"

- **Publication:** *Newsweek*(UVM: 12.4M*)
- "A federal appeals court has struck down a Florida gag rule that barred doctors from talking with their patients about guns, an outcome that gun-safety advocates view as a victory for public safety. The National Rifle Association and the Republican-controlled Florida legislature have long supported the measure. The Atlanta-based 11th U.S. Circuit Court of Appeals on Thursday afternoon found that the measure, formally called the Firearms Owners' Privacy Act, violates doctors' free speech rights and denies patients medical information. Critics of the measure said the law unjustly punishes medical professionals for discussing responsible gun ownership and firearms safety with patients, especially if individuals have children who might come across loaded, unsecured guns at home. Supporters of the law argued such medical discussions would infringe upon an individual's right to bear arms and push an anti-gun agenda."

"Money for Firearms Research Lacking, Harvard Professor Tells Scientists"

- **Publication:** *The Boston Globe*(UVM: 16.6M*)
- "An average of about 100 people nationwide die every day from gun injuries, but funding for firearms research is virtually nonexistent, a Harvard University professor said Friday. David Hemenway, who teaches at Harvard's School of Public Health, described a grim research landscape during the annual meeting of the American Association for the Advancement of Science in Boston. The Centers for Disease Control and Prevention had once set aside $2.6 million annually to study firearm injuries, but that was wiped out in the 1990s under pressure from the gun lobby and congressional Republicans, Hemenway said."

"Gauging Gun Violence in Miami-Dade Complicated by Jumble of Records"

- **Publication:** *Miami Herald*(UVM: 13.2M*)
- "Gauging the scope of gun violence in Miami-Dade — particularly involving young people — is difficult because a jumble of statistics kept by dozens of different police and state agencies can sometimes take

months to be compiled or released to the public. The difficulty in obtaining shooting data echoes broader concerns over researching the effects of gun violence. Decades ago, the U.S. Centers for Disease Control and Prevention used to support research into gun-related injuries, even completing one study in 1993 that found a correlation between having a gun in the house and an increased risk of homicide."

Feb. 18, 2017 **"AG, Medical Society Launch Effort to Help Docs Discuss Gun Safety"**

- **Publication:** *The Telegram* (UVM: 2.5M*)
- "The Massachusetts Medical Society and the state attorney general's office, with endorsement from chiefs of police associations, have released pamphlets and online educational material to help doctors talk voluntarily to patients about another touchy subject: guns in the home and how to keep themselves and family members safe. Health professionals and those familiar with statistics about the more than 33,000 people killed by guns and nearly 79,000 people who survive gunshots each year in the United States, according to the federal Centers for Disease Control and Prevention, applauded the announcement at Boston Medical Center last week as a way to further protect public health."

Feb. 22, 2017 **"The Conversation We Should all be Having About Gun Violence and Firearm Safety"**

- **Publication:** *Charleston City Paper*(UVM: 279.9K*)
- "As with most things, managing gun violence and the flow of firearms in America comes down to money. The Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) — the lead federal agency charged with enforcing federal laws related to firearms — is woefully understaffed. For example, a 2016 Congressional report states that the "ATF has maintained that the agency cannot meet its goal of inspecting every federal firearm licensee for compliance on a three-year cycle." In 2015, ATF agents were only able to complete 6 percent of inspections of the nation's federal firearm licensees. Add that to the rising number of firearms being pumped to the civilian gun stock each year, peaking in 2013 with 16 million firearms introduced to the U.S., and the need for funding the ATF becomes even more obvious. The same can be said for supporting research organizations such as the CDC and National Institutes of Health, which have both struggled to find the necessary financial support to combat gun violence."

"In Harm's Way: Gun Injuries and Deaths Among Florida Kids Have Spiked"

- **Publication:** *Tampa Bay Times*(UVM: 4.1M*)
- "Gun injuries are a growing problem for Florida's children, rising along with the increasing availability of firearms across the state, the Tampa Bay Times has found. When asked why the focus was not on gun injuries and deaths, spokeswoman Mara Gambineri pointed out that the federal Centers for Disease Control and Prevention have funded much of the state's injury prevention efforts. Since 1996, Congressional Republicans have pressured the agency not to fund gun research and safety measures."

Feb. 23, 2017 **"Hypocrites at NRA Aren't Fooling Anyone"**

- **Publication:** *The Hill*(UVM: 58.8M*)
- "In his recent op-ed, "The mentally ill have gun rights, too National Rifle Association (NRA) Executive Director Chris Cox defends the reversal of an Obama-era rule that prohibited those who have been diagnosed with certain mental illnesses and assigned a representative payee by the Social Security Administration from owning a firearm. It is also amusing to note the NRA's sudden commitment to data and evidence-based solutions, as they have held researchers hostage for decades. Through the 1996 Dickey Amendment, the NRA has actively prevented the Center for Disease Control (CDC) from studying gun violence and disseminating data about the best methods to prevent it."

SEXUAL VIOLENCE

Feb. 17, 2017 **"Bill Would Require High Schoolers to Learn About Legal Consent"**

- **Publication:** WAVY - Nexstar Media Group Affiliate: Portsmouth, Va. (UVM: 1.9M*)
- "A bill that would require high schoolers to learn the meaning of legal consent is heading to the governor's desk. Advocates say the goal of early education is to hopefully cut down on troubling numbers when it comes to sexual assaults. The CDC says nearly one in five women have been raped at some time in their lives."

"Let's Stop Treating the Divorce Rate Like the Crime Rate"

- **Publication:** *New York Magazine*(UVM: 31.5M*)
- "In honor of Valentine's Day, Science of Us is spending this week talking about love — specifically, what happens when it goes wrong. If you ever wondered about the psychology of breakups, we've got you covered. Certain statistics are treated as assurances that America is getting more civilized, like the crime rate (mostly) going down, infant mortality decreasing, and life expectancy (mostly) going up. Then there's divorce: The topic is hotly debated, and so is the rate itself."

Feb. 19, 2017 **"Nine Years after His Daughter Was Killed in His Home by Her Ex, Dad Has a Strong Warning for Parents"**

- **Publication:** *Independent Journal Review* (UVM: 21.5M*)
- "Demi Brae Cuccia was a cheerleader at Gateway High School in Pennsylvania, an honor roll student, and an engaged member of her church. According to CBS Pittsburg, Demi and John Mullarkey Jr. had recently ended a tumultuous two-year relationship. In an interview with Independent Journal Review, her father Dr. Gary Cuccia said he knew the couple had broken up but didn't think anything of it at the time. Less than 15 minutes after Mullarkey entered the house, reported the Post-Gazette, the two got into a verbal fight. During the argument, Mullarkey pulled out his 3.5 inch pocketknife and stabbed Demi 16 times. According to the Centers for Disease Control and Prevention (CDC), 21 percent of females and 10 percent of males experienced physical or sexual violence between the ages of 11 and 17. But many instances of teenage violence goes unreported."

Feb. 20, 2017 **"US Researchers Say Funding for Gun Research is Non-Existent But it Would**

Save Lives"

- **Publication:** *Deutsche Welle* (UVM: 29.4M*)
- "More people die due to guns in America than in any other high-income country. But the US congress has restricted funding for gun violence research. Researchers say it's impossible to generate life-saving data."

"Church Response to Domestic Violence Focus of Study"

- **Publication:** *Baptist Press*(UVM: 132.3K*)
- "When it comes to domestic violence, Protestant pastors want to be helpful but often don't know where to start, a new study shows... According to the Centers for Disease Control and Prevention, nearly a quarter of American women (24.3 percent) and 1 in 7 men (13.8 percent) have 'experienced severe physical violence by an intimate partner.'"

Feb. 21, 2017 **"Tips for Protecting Your Teen from an Abusive Relationship"**

- **Publication:** *Miami Herald*(UVM: 13.2M*)
- "Parents often dread the first time their child heads out on a date, worrying about emerging hormones and the emotions in play. However, there is a greater threat to your teen's well-being than a broken heart. According to a 2013 Centers for Disease Control and Prevention survey, one in five girls between 12 and 18 years old experienced teen dating violence. Teen dating violence is physical, emotional or sexual abuse between two teenagers in a relationship. Dating violence can include being hit, kicked or shoved by a partner; being shamed, bullied or verbally demeaned; or being forced into sexual encounters. This abuse often takes place face-to-face, but can occur over the telephone, through text messaging, via social media platforms or online."

"Freedom 180, AMIKids Raise Awareness of Teen Dating Abuse"

- **Publication:** *Panama City News Herald*(UVM: 446.9K*)
- "One in three teenagers has experienced dating violence, according to a 2013 statistic from the Centers of Disease Control (CDC). But Chris Cobb, a student at AMIKids Panama City Marine Institute (PCMI), is surprised that number isn't higher. He has had a number of friends come to him saying they were in abusive relationships and needed advice. Healthy relationships and what a healthy relationship looks like just isn't talked about, he said, and teens don't always feel comfortable going to their parents for advice."

"Letters: Hiring Legal Immigrants Best; More on Presidency"

- **Publication:** *The Gazette*(UVM: 1.2M*)
- "Reduce all relationship violence: February is Teen Dating Violence Awareness Month. While many adults are unaware of the prevalence of teen dating violence, the U.S. Centers for Disease Control (CDC) report that 1 in 4 teens report being hit, slapped, stalked, sexually assaulted or emotionally abused by a dating partner. About 1 in 5 women and nearly 1 in 7 men who ever experienced rape, physical violence, and/or stalking by an intimate partner, first experienced this violence between the ages of 11 and 17."

Feb. 22, 2017

"Groups Work Against Dating Violence: Dating Abuse and Teen Dating Violence Continue to Increase for Girls and Young Women Aged 16-24. "

- **Publication:** *The Daily Iowan*(UVM: 63.0K*)
- "Most would agree that everyone deserves to be in a relationship founded on mutual respect and communication, and free from verbal, emotional, and physical abuse. Unfortunately, according to the Centers for Disease Control and Prevention's Division of Violence Prevention, this is not the reality for millions of Americans. This month, the Women's Resource and Action Center, the Domestic Violence Intervention Program, the Office of the Sexual Misconduct Response Coordinator, and the Rape Victim Advocacy Program have successfully used Teen Dating Violence Awareness and Prevention Month to celebrate and advocate for healthy relationships."

"Recognise Stalking as Domestic Violence"

- **Publication:** *Malay Mail*(UVM: 1.8M*)
- "How many have experienced stalking? A 2013 report by Women's Aid Organisation (WAO) – Malaysia's largest service provider for domestic violence survivors – documented 34 domestic violence cases, of which nine women (26%) had been stalked by their abusers. In the United States, approximately a third of women domestic violence survivors were stalked by their abusers, according to a 2011 Centers for Disease Control and Prevention (CDC) report."

"Teen Dating Violence: More Than Teenage Drama"

- **Publication:** WRAL - Raleigh, N.C. (UVM: 10.4M*)
- **"**February is Teen Dating Violence Awareness month. Teen dating violence is reported as extremely common and starts as early as 11 years old. The question is how parents should recognize the signs and not just dismiss it as teen drama. According to LoveisRespect.org, 1 in 3 teens will experience dating violence. According to the CDC, 23 percent of girls and 14 percent of boys will experience dating violence for the first time between 11 and 17 years old."

"SCV Domestic Violence Center Honored by L.A. County"

- **Publication:** KHTS - Santa Clarita, Calif. (UVM: 99.5K*)
- "SCV Domestic Violence Center (DVC) staff and leadership were honored Tuesday by the county for their work preventing teen dating abuse. February is Teen Dating Violence Awareness Month. Every year, approximately 1.5 million high school students nationwide experience physical abuse from a dating partner, according to the CDC."

Feb. 23, 2017

"Parents: Survey Sex Abuse Questions Went Too Far"

- **Publication:** MagicValley.com (UVM: 545.8K*)
- "Brandy Ramos' 9-year-old daughter has spent the school year learning about adding decimals and the difference between cold-blooded and warm-blooded animals. So earlier this month, Ramos was shocked when she picked up her daughter from school and the third-grader asked her to explain a sex act. The original Adverse Childhood Experiences Study — organized by Kaiser Permanente and the U.S. Centers for Disease Control and Prevention — was given in the mid-

1990s to more than 17,000 southern California adults. It's 'one of the largest investigations of childhood abuse and neglect and later-life health and well-being,' the CDC's website says."

SUICIDE

Feb. 17, 2017 **"Legislators Designate Suicide Prevention Week"**

- **Publication:** MyInforms.com (UVM: 53.7K*)
- "Legislators have passed resolutions to designate the week of Sept. 10 as National Suicide Prevention Week in Virginia. According to the Centers for Disease Control and Prevention, suicide is the 10th leading cause of death in the United States, taking more than 43,000 lives each year. The CDC estimates that more than 1 million Americans attempt suicide annually."

Feb. 20, 2017 **"Gay Marriage Legalization Linked to Drop in Teenage Suicide Attempts"**

- **Publication:** *Medical News Today*(UVM: 10.9M*)
- "In June 2015, the United States Supreme Court ruled that same-sex marriage bans were unconstitutional, enabling homosexual couples across America to marry. A new nationwide analysis suggests the legalization of gay marriage in the U.S. may have led to a drop in suicide attempts among high-school students. According to the Centers for Disease Control and Prevention (CDC), suicide is the third leading cause of death among 10-24-year-olds in the U.S., accounting for 4,600 deaths each year."

"Drop in Teenage Suicide Attempts Linked to Legalisation of Same-Sex Marriage"

- **Publication:** *News Grio*(UVM: 104.0K*)
- **"**Legalisation of same-sex marriage in US states has been linked to a drop in suicide attempts among teenagers. Researchers say suicide attempts among high school students fell by an average of 7% following the implementation of the legislation. The impact was especially significant among gay, lesbian and bisexual teenagers, for whom the passing of same-sex marriage laws was linked to a 14% drop in suicide attempts."

Feb. 21, 2017 **"Marriage Equality Means Fewer Teens are Dying by Suicide"**

- **Publication:** *Dazed Magazine*(UVM: 4.0M*)
- "The legalisation of same-sex marriage in the U.S has been linked to fewer teenagers attempting to take their own lives. Suicide attempts among high school students dropped by 7 percent following the change in marriage laws, according to researchers from John Hopkins University, Harvard and Boston Children's Hospital. The study, carried out across 17 years over 47 U.S states, saw the biggest drop among gay, lesbian and bisexual young people, with 14 percent less suicide attempts. It translates to roughly 134,000 fewer teens. As Forbes reports, it's halfway to the government's federal goal of reducing teen suicide by 10 percent in 2020. Suicide is the second leading cause of death among 15 to 24-year-olds, according to the U.S Centres for Disease Control and Prevention, with numbers rising significantly among LGBTQ people."

"Teen Suicide Attempts Fell as Same-Sex Marriage Became Legal"

- **Publication:** *Bradenton Herald*(UVM: 729.0K*)

- "Teen suicide attempts in the U.S. declined after same-sex marriage became legal and the biggest impact was among gay, lesbian and bisexual kids, a study found. The research found declines in states that passed laws allowing gays to marry before the Supreme Court made it legal nationwide. The results don't prove there's a connection, but researchers said policymakers should be aware of the measures' potential benefits for youth mental health. Suicide is the second-leading cause of death for all U.S. teens. Suicidal behavior is much more common among gay, lesbian and bisexual kids and adults; about 29 percent of these teens in the study reported attempting suicide, compared with just 6 percent of straight teens."

"Same-Sex Marriage Laws May Reduce Teen Suicide Attempts by 134K"

- **Publication:** *Seeker*(UVM: 3.6M*)
- "Researchers at Johns Hopkins University found that suicide attempts among gay, lesbian and bisexual teenagers dropped by 14 percent following the legalization of gay marriage on the state level."

"Same Sex Marriage Legalization May Have Cut Teen Suicide Attempts"

- **Publication:** *Fortune*(UVM: 1.2M*)
- "Policies legalizing same sex marriage are correlated with fewer youth suicide attempts, especially among teenagers who are sexual minorities, according to a new study. Researchers from Johns Hopkins' Bloomberg School of Public Health analyzed data from both states that had and hadn't legalized same sex marriage prior to 2015, when the Supreme Court issued a decision legalizing it across the country. "After same-sex marriage laws were implemented, the proportion of high school students reporting suicide attempts in the past year decreased by 0.6 percentage points, equivalent to a 7% decline," wrote the authors. States that had not legalized same sex marriage did not see these declines."

"Teen Suicide Rates Dropped After Same-Sex Marriage Was Legalized, Study Finds"

- **Publication:** *Vice*(UVM: 19.9M*)
- "Policies legalizing same sex marriage are correlated with fewer youth suicide attempts, especially among teenagers who are sexual minorities, according to a new study. Researchers from Johns Hopkins' Bloomberg School of Public Health analyzed data from both states that had and hadn't legalized same sex marriage prior to 2015, when the Supreme Court issued a decision legalizing it across the country. "After same-sex marriage laws were implemented, the proportion of high school students reporting suicide attempts in the past year decreased by 0.6 percentage points, equivalent to a 7% decline," wrote the authors. States that had not legalized same sex marriage did not see these declines."

"Why Teen Suicide Rate Has Dropped Since Same-Sex Marriage Was Legalized"

- **Publication:** *Vix*(UVM: 37.3M*)
- "A study published in The Journal of the American Medical Association

found that suicide rates for LGBTQ teens have gone down 7 percent after the legalization of same-sex marriage. The study looked at suicide rates in teenager between 1999 and 2015, which was the year that the Supreme Court legalized same-sex marriage across the nation."

"Teen Suicide Attempts Declined After Same-Sex Marriage Became Legal, Study Finds"

- **Publication:** KDVR - Fox Affiliate: Denver, Colo. (UVM: 2.5M*)
- "Suicides have become the second-leading cause of death among people aged 15 to 24 in the United States. But researchers say the legalization of same-sex marriage may be a source of hope for some teens. According to the Centers for Disease Control and Prevention, almost 30 percent of gay, lesbian and bisexual high school students reported attempting suicide, compared to 6 percent of heterosexual students."

"Spring and Summer Months More Common for Suicide"

- **Publication:** KCRG - ABC Affiliate: Cedar Rapids, Iowa (UVM: 1.29M*)
- "According to the CDC, more people in the United States complete suicide in the spring and summer months, than during the rest of the year. Crisis agency Foundation 2 experiences that first hand. 'As spring comes and things are starting to be reborn, the flowers are coming out, and the weather is warming up, people feel better. If you're depressed, you feel that much more of a distance between yourself, and your world around you, and the people around you,' counseling supervisor Nancy Oehlert said."

Feb. 22, 2017 "Marriage Equality Laws Associated With Drop in LGBTQ Teen Suicide Rate"

- **Publication:** *She Knows*(UVM: 13.0M*)
- "A new study published in JAMA Pediatrics found that across 47 states, same-sex marriage policies were associated with a 7 percent reduction in high school students who reported a suicide attempt in the past year — particularly among adolescents who were sexual minorities. Suicide is the second-leading cause of death for people ages 15 to 24 (the first is unintentional injury). According to the CDC, the attempted suicide rate is four times higher among lesbian, gay and bisexual adolescents, so the potential impact of marriage equality laws on this population is especially significant."

"LGBT Teen Suicide Attempts Fell with the Rise of Marriage Equality: STUDY"

- **Publication:** *Towleroad*(UVM: 2.3M*)
- "A link has been found between the legalization of gay marriage and a drop in the suicide rates of LGBT teenagers. A study compiled by researchers from John Hopkins University, Harvard University and Boston Children's Hospital and published this week in the journal Jama Pediatrics has determined that in US states where marriage equality was passed, the suicide rate among LGBT teenagers fell around 14%."

"Legal Same-Sex Marriage Reduces Youth LGBT Suicide Rates"

- **Publication:** *Elle UK*(UVM: 1.0M*)
- "In a world of bad news and fake news, isn't it good to hear some good news? Since 2015 the US called State-level bans on same-sex marriage unconstitutional, meaning that the slow and hard-fought battle of

marriage equality was finally won. Though many LGBT people may not have even wanted to exercise this potential freedom, many argued it was important to be seen equally in the law and thus, society en-masse."

"Legalized Same-Sex Marriage Linked to Lower Rates of Suicide Attempts Among Teens"

- **Publication:** *Nature World News*(UVM: 401.1K*)
- "A new study revealed that teens living in states that have legalized same-sex marriage were less likely to attempt suicide. The study, published in the journal JAMA Pediatrics showed a link between the legalization of same-sex marriage in some states and the drop of suicide rates among teens in the same area."

"Same Sex Marriage Laws Associated with Drop in Suicide Rates Among High School Students"

- **Publication:** *Axis of Logic*(UVM: 59.6K*)
- "States that legalized same-sex marriage before it became federal law two years ago saw a sharp decline in suicide attempts by high school students, according to an analysis by researchers at the Johns Hopkins Bloomberg School of Public Health."

"A Study Shows That Legalization of Same Sex Marriages is Linked to a Lower Teen Suicide Rate"

- **Publication:** *Her Campus*(UVM: 2.5M*)
- "So there's a pot of gold at the end of that rainbow flag—The legalization of same sex marriage may have reduced the teen suicide rate. In a study published Monday by the Johns Hopkins University School of Public Health, researchers found suicides decreased in high school students, particularly LGBT students, when a state legalized same sex marriage prior to the Supreme Court decision."

"Using Analytics to Improve Suicide Prevention"

- **Publication:** *Healthcare IT News*(UVM: 378.2K*)
- "The Substance Abuse and Mental Health Services Administration (SAMHSA)-funded Zero Suicide project works under the belief that suicide deaths for individuals under care within health and behavioral health systems are preventable. The project uses a combination of best evidence, best practices and innovative practices to prevent all suicides. It is an aspirational goal, but a valuable one. These prevention efforts rely on clinicians, including physicians, nurses and social workers, to follow best practices and evidence to move toward that goal."

Feb. 23, 2017

"CDC Surveys Cleveland Schools' Suicide Rate"

- **Publication:** *Ideastream*(UVM: 195.9K*)
- "More than 20% of Cleveland Metropolitan School District students surveyed by the Centers for Disease Control reported having attempted suicide in 2015. Out of 19 urban school districts surveyed across the United States, Cleveland had the highest rate of attempted suicide."

"Cleveland School District has Highest Suicide Rates in U.S."

- **Publication:** News Talk 1490 - Cleveland, Ohio (UVM: 871.1K*)
- "According to the CDC, more high school students in Cleveland are

attempting to take their own lives, than in any other American city. Two out of every ten high school student enrolled in Cleveland Metropolitan Schools, according to the CDC, tried to kill themselves in 2015. Twenty percent of the CMSD high school population is suicidal; one of the highest numbers in the United States."

VIOLENCE PREVENTION (GENERAL)

Feb. 18, 2017 **"Advocates Hope to Create Anti-Violence Groundswell"**

- **Publication:** *St. Cloud Times*(UVM: 340.6K*)
- "Katie Cashman championing Green Dot, a bystander intervention-based program that's meant to encourage widespread community action and cultural change. The shift is being propelled by Anna Marie's Alliance and the Central Minnesota Sexual Assault Center, two local nonprofits that deal with the aftermath violence can have, particularly on women and children. Green Dot is a program that trains community members to end and prevent violence, by encouraging people — bystanders — to do something."

* Total unique visits per month of publication's website (within one month prior to date reported)

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 2 Feb 2016 16:27:18 -0500
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: For Review: The Trace-gun violence

Hi Deb,
Kate Masters with The Trace requested an interview with you, originally stating she wanted to discuss: *"My article is going to be about violence research at the CDC versus the NIH, so most of my questions would center on her approach to running the Center for Injury Control and Prevention, accomplishments she's made, and priorities she'd still like to work on."*
Based on prior requests she has had with us (Wilmington and gun violence) and with NIH, I asked for specific questions that we could address via email. Here they are. Responses have been reviewed/revised with Linda Dahlberg, OPP has also been in the loop. Responses are primarily pulled from our cleared Q&A on the issue. I will also get HHS clearance once you review.
Thank you!
Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence, therefore we decline to comment on theoretical consequences.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. There is nothing in CDC's appropriation language that prevents the agency from conducting gun violence research. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.

- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why? (approved/reviewed by Division of Population Health)

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached

Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm

Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm

Most recent NVDRS Surveillance Summary:

Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010

MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

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ral nonadjacent decedents (9.3%) than urban decedents (13.2%). Physical health problems were more commonly cited among rural nonadjacent decedents (24.4%) than rural adjacent (23.4%) or urban (20.9%) decedents.

Discussion

In this study of individual suicide decedents from 2006 to 2008, decedents in urban areas differed significantly from those in rural areas with respect to multiple demographic, mental health, and suicide event characteristics. There were four notable findings in this study. First, there were significant differences in mental health characteristics between urban and rural decedents. Second, there was a correlation between urban–rural status and history of financial, employment, substance abuse, and physical health issues. Third, consistent with prior work, rural decedents were more likely to use a firearm as the method of suicide. Finally, there was an identifiable relationship between proximity to an urban center and the mental health characteristics of rural decedents. It is important to note that the findings from this descriptive study of completed suicides cannot be used to infer causal relationships between various factors and suicide risk. Nonetheless, these study results are useful for identifying potential risk factors, evaluating previous theories, and informing future suicide research and interventions.

Mental Health and Treatment History

In this study, rural decedents were less likely than urban decedents to have had a current mental health diagnosis, a previous history of mental health treatment, or a previous suicide attempt. These results are consistent with previous research findings nationally and internationally that rural individuals are less likely to be diagnosed with and receive treatment for mental health problems than urban individuals (Crawford & Brown, 2002; Fiske et al., 2005; Taylor et al., 2005). There are multiple plausible explanations for this. Previous research has found that stigma regarding mental illness may be greater in rural communities, so that those suffering from mental illness may isolate themselves rather than seek help from their community (Crawford & Brown, 2002). The differences in mental health treatment rates between urban and rural decedents in this study may also be explained by the theory that social isolation is greater in rural communities (Trout, 1980). With increased social isolation, it is less likely that an at-risk individual will be identified. Additionally, social isolation in and of itself may affect risk. Finally, given the increased rates of firearm use by rural decedents, it is also plausible that rural decedents actually have lower rates of longstanding mental health problems and instead exhibit higher suicide rates owing to a higher lethality of impulsive attempts. Further research is necessary to determine which of these theories, if any, explain the lower treatment rates seen among rural decedents.

While, overall, rural nonadjacent decedents were less likely to be in treatment at the time of death than urban decedents, those with a reported depressed mood were equally likely to be in treatment, regardless of urban–rural status. It is not possible to determine conclusively what explains this difference based on information available in the NVDRS, but these findings suggest that future research should examine variations in access to and utilization of mental health treatment. In addition, an important finding is that among all groups of decedents, including the reported depressed mood group, treatment rates were less than 41%. This finding supports previous evidence that in both urban and rural areas there are substantial obstacles to treating individuals with mental health issues that produce low rates of utilization in national and international communities (Hyman, 2000; Gonzalez et al., 2010; The ESEMeD/MHEDEA 2000 Investigators., 2004). This highlights the importance of identifying these obstacles in future research to enhance suicide prevention in all community types.

Suicide Circumstances

Factors that were more prevalent among urban decedents than rural decedents included history of substance abuse, job, and financial problems. These results appear to contradict previous theories that cite increased alcohol and substance abuse and more pervasive job and financial insecurity as factors that increase rural suicide risk (Taylor et al., 2005). However, from this analysis of only decedents we cannot estimate the magnitude of such social problems in the general population in each area, and the NVDRS lacks some important economic variables. It is also worth noting that this analysis included suicide deaths that mostly occurred prior to the economic crisis that began in late 2008. Further research is necessary to determine whether urban dwellers in included counties have a higher incidence of these problems or instead have comparable rates of these problems but are somehow less able to cope with them. Rural nonadjacent decedents were also more likely to have a physical health problem cited as a contributing factor.

Use of Firearms

The increased use of firearms by rural decedents was one of the most obvious differences between urban and rural cases. This finding is consistent with results of community-based analyses (Andres & Hempstead, 2011) and supports lethal means restriction as an essential component of suicide prevention efforts (Daigle, 2005; Hawton, 2007; Lewiecki, 2013; Miller & Hemenway, 1999, 2008).

Proximity to Urban Center

Multiple mental health and suicide characteristics of rural decedents varied with proximity to an urban center. Nota-

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What Do We Know About the Association Between Firearm Legislation and Firearm-Related Injuries?

Julian Santaella-Tenorio*, Magdalena Cerdá, Andrés Villaveces, and Sandro Galea

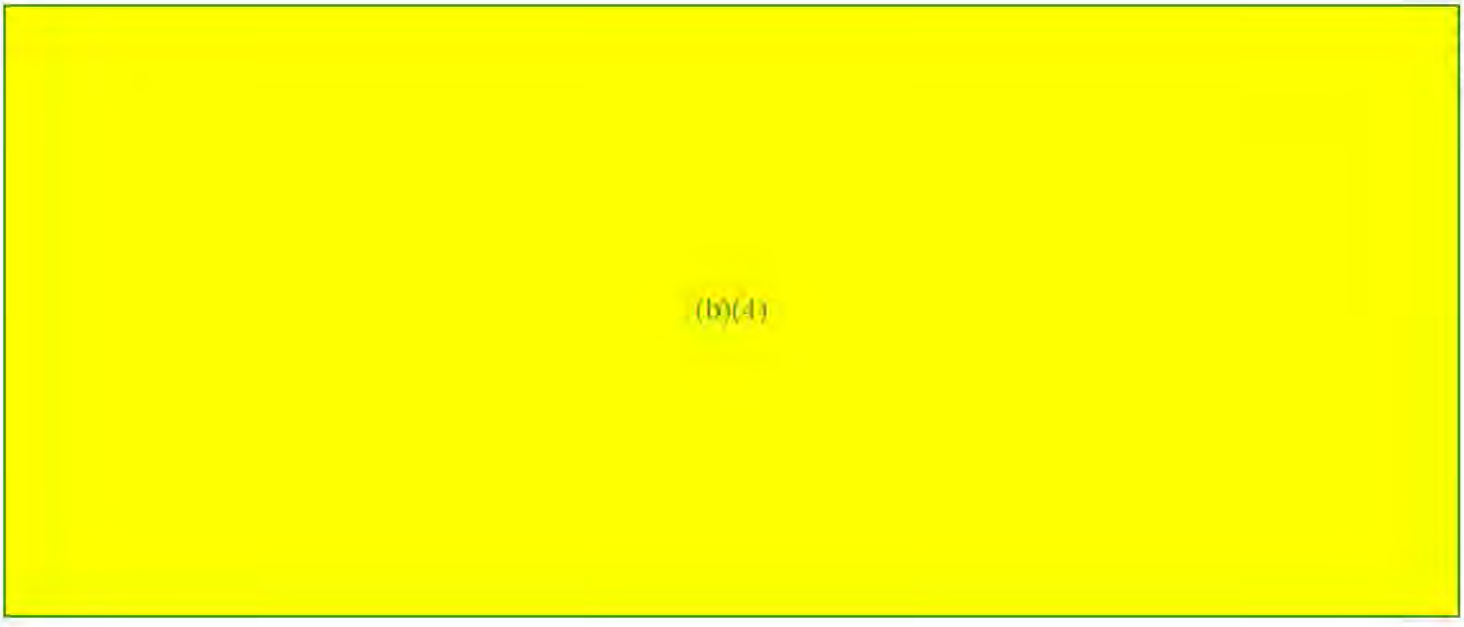
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Accepted for publication September 4, 2015.

Firearms account for a substantial proportion of external causes of death, injury, and disability across the world. Legislation to regulate firearms has often been passed with the intent of reducing problems related to their use. However, lack of clarity around which interventions are effective remains a major challenge for policy development. Aiming to meet this challenge, we systematically reviewed studies exploring the associations between firearm-related laws and firearm homicides, suicides, and unintentional injuries/deaths. We restricted our search to studies published from 1950 to 2014. Evidence from 130 studies in 10 countries suggests that in certain nations the simultaneous implementation of laws targeting multiple firearms restrictions is associated with reductions in firearm deaths. Laws restricting the purchase of (e.g., background checks) and access to (e.g., safer storage) firearms are also associated with lower rates of intimate partner homicides and firearm unintentional deaths in children, respectively. Limitations of studies include challenges inherent to their ecological design, their execution, and the lack of robustness of findings to model specifications. High quality research on the association between the implementation or repeal of firearm legislation (rather than the evaluation of existing laws) and firearm injuries would lead to a better understanding of what interventions are likely to work given local contexts. This information is key to move this field forward and for the development of effective policies that may counteract the burden that firearm injuries pose on populations.

death; firearms; homicide; legislation; suicide; weapons; wounds and injuries

Abbreviations: NCHS, National Center for Health Statistics; NFA, National Firearms Agreement; UCR, Uniform Crime Reports.



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Effectiveness of Interventions to Promote Safe Firearm Storage

Ali Rowhani-Rahbar*, Joseph A. Simonetti, and Frederick P. Rivara

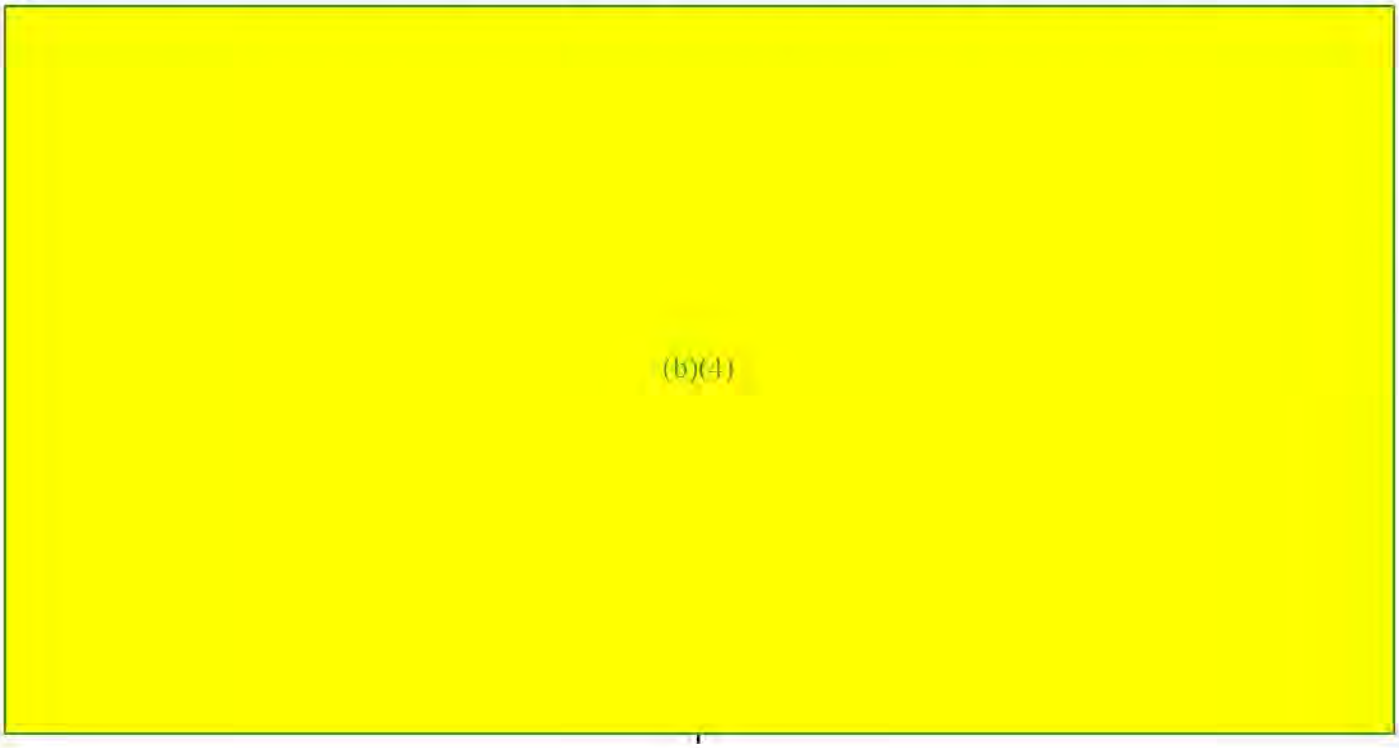
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Despite supportive evidence for an association between safe firearm storage and lower risk of firearm injury, the effectiveness of interventions that promote such practices remains unclear. Guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist, we conducted a systematic review of randomized and quasi-experimental controlled studies of safe firearm storage interventions using a prespecified search of 9 electronic databases with no restrictions on language, year, or location from inception through May 27, 2015. Study selection and data extraction were independently performed by 2 investigators. The Cochrane Collaboration's domain-specific tool for assessing risk of bias was used to evaluate the quality of included studies. Seven clinic- and community-based studies published in 2000–2012 using counseling with or without safety device provision met the inclusion criteria. All 3 studies that provided a safety device significantly improved firearm storage practices, while 3 of 4 studies that provided no safety device failed to show an effect. Heterogeneity of studies precluded conducting a meta-analysis. We discuss methodological considerations, gaps in the literature, and recommendations for conducting future studies. Although additional studies are needed, the totality of evidence suggests that counseling augmented by device provision can effectively encourage individuals to store their firearms safely.

firearms; program evaluation; safety

Abbreviations: DVRO, domestic violence restraining order; IPH, intimate partner homicide; IPV, intimate partner violence.



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Firearm injuries in the United States

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ABSTRACT

Objective. This paper examines the epidemiology of fatal and nonfatal firearm violence in the United States. Trends over two decades in homicide, assault, self-directed and unintentional firearm injuries are described along with current demographic characteristics of victimization and health impact.

Method. Fatal firearm injury data were obtained from the National Vital Statistics System (NVSS). Nonfatal firearm injury data were obtained from the National Electronic Injury Surveillance System (NEISS). Trends were tested using Joinpoint regression analyses. CDC Cost of Injury modules were used to estimate costs associated with firearm deaths and injuries.

Results. More than 32,000 persons die and over 67,000 persons are injured by firearms each year. Case fatality rates are highest for self-harm related firearm injuries, followed by assault-related injuries. Males, racial/ethnic minority populations, and young Americans (with the exception of firearm suicide) are disproportionately affected. The severity of such injuries is distributed relatively evenly across outcomes from outpatient treatment to hospitalization to death. Firearm injuries result in over $48 billion in medical and work loss costs annually, particularly fatal firearm injuries. From 1993 to 1999, rates of firearm violence declined significantly. Declines were seen in both fatal and nonfatal firearm violence and across all types of intent. While unintentional firearm deaths continued to decline from 2000 to 2012, firearm suicides increased and nonfatal firearm assaults increased to their highest level since 1995.

Conclusion. Firearm injuries are an important public health problem in the United States, contributing substantially each year to premature death, illness, and disability. Understanding the nature and impact of the problem is only a first step toward preventing firearm violence. A science-driven approach to understand risk and protective factors and identify effective solutions is key to achieving measurable reductions in firearm violence.

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Abstract:
Introduction: A youth's emergency department (ED) visit for suicidal behaviors or ideation provides an opportunity to counsel families about securing medications and firearms (i.e., lethal means counseling).

Methods: In this quality improvement project drawing on the Counseling on Access to Lethal Means (CALM) model, we trained 16 psychiatric emergency clinicians to provide lethal means counseling with parents of patients under age 18 receiving care for suicidality and discharged home from a large children's hospital. Through chart reviews and follow-up interviews of parents who received the counseling, we examined what parents recalled, their reactions to the counseling session, and actions taken after discharge.

Results: Between March and July 2014, staff counseled 209 of the 236 (89%) parents of eligible patients. We conducted follow-up interviews with 114 parents, or 55% of those receiving the intervention; 48% of those eligible. Parents had favorable impressions of the counseling and good recall of the main messages. Among the parents contacted at follow up, 76% reported all medications in the home were locked as compared to fewer than 10% at the time of the visit. All who had indicated there were guns in the home at the time of the visit reported at follow up that all were currently locked, compared to 67% reporting this at the time of the visit.

Conclusion: Though a small project in just one hospital, our findings demonstrate the feasibility of adding a counseling protocol to the discharge process within a pediatric psychiatric emergency service. Our positive findings suggest that further study, including a randomized control trial in more facilities, is warranted.

Supporting material:
Figure
Figure


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Lethal Means Counseling for Parents of Youth Seeking Emergency Care for Suicidality

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Federal Partners Meeting
Discussion Summary

Introduction

A meeting of representatives from the Departments of Education, Health and Human Services, and Justice, met in Washington, DC, on February 19-20, 2014, to discuss current efforts and future opportunities associated with firearm violence prevention research. The meeting objectives were to: 1) discuss approaches for strengthening data to understand patterns and characteristics of firearm violence and to address research questions; 2) ensure that research carried out by the different agencies is complementary and builds upon individual and collective strengths, and 3) determine opportunities to collaborate on current or future efforts.

The meeting was broken into four sessions. During the first day, discussion focused on exploring the current environment of firearm violence prevention research (Session 1) and the data associated with it (Session 2), particularly identifying gaps and what resources could be brought to bear on them. The second day built upon these conversations and explored how to create a complementary approach that builds upon individual and collective strengths (Session 3). It ended with a focused discussion on what actions could be taken to enhance coordination, communication, and collaboration (Session 4) between the Departments.

Throughout the discussions, participants were encouraged to share information and ideas about each of the respective topics. However, there was no push to reach consensus or set priorities. Instead, through a series of facilitated discussions, participants were asked to react or respond to various topics or questions posed. In addition, the discussion topics built upon information gleaned from previous conversations the facilitators had with many of the participants prior to the meeting.

This report summarizes the main themes that emerged from these discussions and should not be construed as reflecting official policies or positions of the meeting participants or the departments/agencies represented.

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DAY 1

Session 1 – Research Discussion

This first discussion was designed to better understand what firearm violence prevention research is currently being undertaken, identify what research gaps exist, and where particular research interests lie among the respective departments/agencies. Participants were given a document entitled *Research Discussion Handout* (Appendix A), which contained a list of research topics that emerged from interviews conducted prior to the meeting or were included in the recent Institute of Medicine/National Research Council (IOM/NRC) report, *Priorities for Research to Reduce the Threat of Firearm-Related Violence.* These topics were grouped under four topic headings: 1) access to firearms; 2) technological approaches; 3) triggers and influences of violence involving firearms; and 4) intervention strategies, policies, programs, that might prevent firearm violence. Working in small groups, participants were asked to review the list and contributed individually and as a team by keeping the following instructions at the forefront:

1. Discuss and identify any research gaps that may be associated with a respective category.
2. Share with your colleagues where your current work may be touching upon some of these research topics or themes.
3. Identify any research areas or information sharing opportunities where complementary efforts exist or would be beneficial in the future.

Various responses emerged from these discussions and this feedback is grouped under the initial headings (mentioned above) for which it corresponded.

Access to Firearms

Much of the discussion in this area focused on the fundamental questions surrounding access to firearms and its influence in precipitating a violent act or event. In this vein, discussion focused on the need to better understand access as it relates to certain vulnerable populations (e.g., youth, young adults, persons with suicidal intentions) and settings (e.g., schools, businesses, public housing). Likewise, understanding the various risk and protective factors that result from access to a firearm was identified as an important research area. In particular, exploring the nuances associated with using a firearm for defensive purposes in various situations and settings was recognized as a needed study area. Participants also raised the need for research exploring access as it relates to unintentional firearm injuries and nonfatal violence-related firearm injuries. At this point, several participants indicated that while these were important areas for exploration, data was largely lacking in these areas, particularly at the state and local level, which would make studies more difficult to pursue.

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In addition, participants discussed the need to better understand the physical characteristics of access as it related to both storage and acquisition. Questions about ownership and storage were important ones for exploration. Participants noted that questions on ownership and storage practices were included in the Behavioral Risk Factor Surveillance System, but those questions have not been included since 2004. A suggestion was made to look back at those research questions and possibly include them into existing surveys. In another category, the need for better preventative practices and messaging around safe storage was suggested.

Participants also noted that additional research to understand the distinction between access, ownership, and use, was an important area for consideration. For example, persons with access to firearms do not necessarily own them. Finally, another area of discussion was the need to better understand the firearm supply line and secondary markets, including online and private sales, and their correlation to access issues.

Technological Approaches

A large portion of the discussion on this topic focused on discussing new technological approaches that were being developed and their possible implications for firearm violence. For instance, technology solutions for smart guns were mentioned as one avenue currently being evaluated. A review of patent filings found that the technology is quite mature, incorporating such techniques as locking mechanisms using biometric readers, creation of safe zones that disable guns and alerts sent to the owner via a mobile application when a firearm is moved. There are, however, questions around acceptance and adoption of these technologies, particularly the possible impact these technologies might have on various professional sectors (e.g., police, private security) in performing their duties. Likewise, the emergence of new technologies such as 3-D printing bring into play a whole new set of research questions and the discussion then turned into considering how ammunition fit into the equation. As several participants indicated, ammunition's role in firearm violence is not well understood nor is its possible use as an intervention strategy. In wrapping up this discussion, it was suggested that one approach might be to routinely conduct forecasting research on the availability of technologies and their impact.

Finally, as a corollary to the technology discussion, participants also noted the need to generate greater awareness and recognition regarding gun safety. Participants discussed different research areas that could be explored to better understand consumers' attitudes towards existing or new gun safety technologies and how compliant they would be with them. Participants noted that lots of lessons could be learned from other areas where promoting safe behavior has prevented injuries or deaths.

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Triggers and Influences

As expected, the conversations here reiterated a lot of the same research topics/themes found under this heading in the handout provided to participants. Much discussion focused on the need to better understand the genetic, neurological or behavioral basis of substance abuse, especially alcohol and drugs, in violent events involving firearms. In addition, it was suggested that the need to distinguish between abuse and use as it relates to both alcohol and drugs was an important consideration. Alcohol use does not necessarily infer abuse and yet both may be important areas to explore to better understand the relationship between alcohol and firearm violence. Likewise, the impact of different drugs on decision-making and its correlation to firearm violence was another area that warranted examination. Finally, rather than examining alcohol and drugs separately, the importance of assessing how the use of both alcohol and drugs may influence decision-making was also noted.

Considerable discussion also ensued about the role of situational and contextual factors in influencing violence involving firearms. In particular, participants noted the need to better understand the relationship between alcohol availability and firearm violence. Grants have been awarded in the past to examine this area and while a relationship between alcohol availability and violence in general has been shown, further research is warranted on the relationship between availability and firearm violence specifically. It was noted that the IOM has been commissioned to conduct a systematic review of the literature on the relationship between alcohol and firearm violence.

Participants also suggested that a community focus to the research was critical. This approach would allow more in-depth research and the ability to detect patterns and determine precipitating factors, as well as design interventions unique to localities. It also would assist in tracking firearm violence more closely across geographic settings. Participants also suggested that a community focus might help better identify those populations most at risk and those individuals or groups to tailor prevention messages or interventions.

The individual factors that may trigger or influence violence involving firearms were contemplated as well. Mental health's role and its importance as a research topic was highlighted, particularly given recent events that have focused attention on mental health's relationship to firearm violence. In addition, participants suggested that more research is needed to understand the perpetrator and victim relationship and its connection to firearm violence. In a similar fashion, examining the impact and repercussions of a violent incident upon both victims and perpetrators was another important study area identified. A life course approach to individual factors also was deemed critical to understand the developmental trajectory—child, teen, adult, elderly.

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Finally, research to better recognize the influence of social media, visual media, and marketing on firearm violence is warranted, particularly how exposure to violent media may trigger or influence violence involving a firearm.

Intervention Strategies, Policies, and Programs

A consistent theme that emerged from the discussions was the need for more research to identify which intervention strategies, policies, or programs effectively prevent firearm violence. At a minimum, participants recommended taking stock of what currently exists in terms of evidence-based interventions and assessing whether they are ready to be scaled up or implemented. This approach could help identify areas where research is sufficient and where gaps still exist.

In addition, the utility of evidence-based interventions in other areas also was raised. For instance, evidence-based programs addressing risk and protective factors associated with other public health issues (such as alcohol and substance abuse) might be adapted for firearm violence prevention. Another possibility could be assessing the applicability of skill-based programs for youth in preventing firearm violence; the assumption being that these programs generally reduce alcohol, drug, and tobacco use, as well as juvenile delinquency, so they might be extended to addressing firearm violence as well. However, caution was recommended since the same characteristics or assumptions would not necessarily apply. There is still a need to assess whether these strategies effectively reduce firearm violence.

These suggestions led to other resources or interventions being mentioned. CrimeSolutions.gov is a repository for research on the effectiveness of programs and practices in criminal justice, juvenile justice, and crime victim services. Blueprints for Healthy Youth Development is another repository of effective violence prevention programs. In terms of specific interventions, violence interrupter strategies (e.g., CeaseFire, Cure Violence) could be explored further since a lot of what they're doing in the midst of the conflict is to broaden someone's perspective; this speaks to disrupting some of the influences or triggers that may lead to violence involving a firearm.

Discussions also centered on the need for more systematic reviews of local, state, and national policies, to determine their effectiveness in preventing firearm violence. While there was a general agreement about this need and its merits, the research gaps previously identified may yield the same conclusions as earlier systematic reviews because many of the gaps have not been addressed by research. As an example, it was noted that the last time this was undertaken by the Community Preventive Services Task Force about 10 years ago, they found that the evidence available was insufficient to determine the effectiveness of any of the firearm laws reviewed singly or in combination (e.g., waiting periods, background checks, etc.) to prevent violence or reduce violent outcomes. If such a review were to be undertaken, participants noted the importance of also taking into account the

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difference between the policy enacted and how it's implemented. As participants noted, enforcement authorities interpret policies differently and this has a direct impact on how the policy gets implemented within the community. At a minimum though, it was suggested that a repository that keeps a list of all firearm laws or policies should be made available to researchers as one means to encourage future policy evaluation research.

The need to assess the effectiveness of setting specific strategies also was cited by several participants. Settings mentioned included schools, workplaces, and homes. As was noted, numerous strategies, policies, and programs have been implemented in these settings, particularly schools and workplaces, but it's not clear whether they are effective, and if the evidence exists, it's not widely known. In particular, much emphasis has been placed on preparedness and response strategies in these settings but it's not clear what works or if they can be applied to other settings. Likewise, communication and message campaigns reaching parents are popular strategies but few studies have been conducted to determine whether these education efforts are translating into increased awareness and better preparedness in their children. In a similar fashion, several programs aimed at healthcare providers enlist them to encourage gun safety in the home as well as assess risk. Yet, it's not clear whether these protocols are producing intended outcomes.

Session 2 – Data Collection Discussion

This session was designed in a similar fashion to the research discussion. Participants were given a document entitled *Data Collection Discussion Handout* (Appendix B), which consisted primarily of data gaps identified through the phone interviews. Once again, each table reviewed the list and contributed individually and as a team by keeping the following instructions at the forefront:

1. Share with your colleagues where your current work may be touching upon some of these identified data gaps.
2. Discuss and identify any other data gaps that may be associated with a respective category. In essence, do we have the necessary data to examine the research questions or themes outlined in the earlier session?

A number of data topics emerged, though none went outside of the broad categories identified in the interviews conducted with participants prior to this meeting. The school setting, both K-12 and college campuses, was a popular point of discussion. Most participants believed that there is much awareness around school violence from both a political and general public standpoint, but there are tremendous gaps in both research and data gathering to either understand these aspects or prevent this type of firearm violence. At the same time, the data that does exist in this area is very limited. A National Center for Education Statistics (NCES) survey focused on the various reasons why students carry weapons to school and the prevalence of expulsions along with other data points. Information on types of weapons and ammunition is available but it is all event-specific.

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CDC, in collaboration with the Departments of Education and Justice, has been tracking school-associated violent deaths since 1992. School-associated violent deaths include those that occur on school property, on the way to/from school, and at school-sponsored events. This is an important data collection system that could be better utilized to understand the characteristics of these events and possible strategies to prevent school shootings.

Certainly, participants as a whole identified the need for community data along with state and national data, but recognized that there are barriers to this type of data collection. For instance, one agency experimented with gathering local data in hard-to-reach populations such as just booked arrestees, offenders involved in other criminal behavior (drug trafficking, domestic violence, etc.). While this information is viewed as having great value, data collection of this type proved to be cost-prohibitive. Generally speaking, the team felt as though any research or data that has "cross-over" elements to firearm violence such as substance abuse, mental illness, etc., as well as being conducted and gathered on the community level, is both extremely valuable and costly, but very necessary. As part of this discussion, analysis capability and capacity on the local level presented as an issue. The question of who would analyze the data and who would absorb the cost of this analysis was a concern; involving local academics and academic institutions and research practitioners was seen as necessary. The "Communities That Care" platform was cited as worth looking into as a model for collaboration and data utilization on the community level.

One of the primary research focus areas that came out of both the IOM/NRC report and the interviews is risk and protective factors. While various data gaps were identified within this area, the general perspective was that data gathering has largely centered on risk factors and, although gaps still exist with respect to understanding risk factors, more is needed to understand protective factors.

Participants noted a number of other important data gaps – including a lack of good information on gun ownership, attitudes about guns, reasons and motivations for gun ownership, and what types of gun and what types of owners end up owning a crime gun. Other gaps noted include a lack of information on gun purchases, including information on timing and characterization, particularly for adults at risk of completing suicide. Participants also noted the importance of context and understanding the circumstances surrounding events. The lack of data at the local and state level on nonfatal firearm violence was also mentioned as a significant gap as well as information on cost of firearm injury.

The ability to and necessity of linking specific types of data was paramount throughout the day. In particular, participants felt that many current research gaps could be addressed if data were more standardized, more easily linked, and more complete. There is a lot of variability across data sets in the way deaths, assaults, behaviors, and circumstances are classified. Some participants noted that the National Violent Death Reporting System (NVDRS) links and pulls in various data sources including death records, law enforcement

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reports, and coroner/medical examiner reports and allows for some potential linkage with other data sources. The National Vital Statistics System (NVSS) provides another linkage opportunity by asking coroners or medical examiners to add new data fields that might provide more information associated with the cause of death. Other linkage areas included connecting local crime data with emergency department data from local hospitals, and connecting with private data systems (i.e., insurance information; partner organization such as Gallup). The importance of data linkage to facilitate longitudinal studies to better understand the long-term impacts of firearm violence was also noted. At this time, according to the majority of the group, there is a lack of long-term studies in the area of firearm violence.

There is also a need to make data more widely accessible for analysis and reporting. The Web-based Injury Statistics Query and Reporting System (WISQARS) was recognized as an interactive database that might be a good foundation for infrastructure to make various types of data easily available for analysis and reporting.

There was a suggestion to look outside of firearm violence prevention research to find some "best practices" in research and data collection and subsequent unexpected utilization. For example, there was mention of possibly applying surveillance and sampling methods utilized in HIV/AIDS research, in particular looking at snowball sampling versus respondent-driven sampling. The design of specific transportation and traffic data collection systems is a very deliberate and collaborative effort between the Department of Transportation (DOT), the National Traffic Safety Administration (NTSA), and other agencies and is customized for local, state, and national levels.

Finally, there was a brief discussion around policy implications and impact and the need for more data in this area. Most of this was a follow-up to the need for more policy evaluation research. Although, it should be mentioned that understanding the impact of policies on all levels (i.e., state, national, local) and across all categories (i.e., access in different populations) was an underlying theme throughout the discussion.

DAY 2

Session 3 – Building on Individual and Collective Strengths

A main goal of the meeting was to ensure the research carried out by the different agencies is complementary and builds upon individual and collective strengths. To tackle this goal, participants concentrated on particular aspects within the research and data collections arenas. For research, questions were posed to the participants to help define what constitutes a strategic investment and a complementary approach. These questions led to robust discussion about current priority setting processes (and related criteria) used by the various federal agencies to guide resource allocations. Participants also spent time

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describing the characteristics of a complementary approach and possible methods for ensuring that the approach builds upon individual or collective strengths.

Returning to the data collection topic, participants tackled three themes that emerged during the previous day's discussion; namely how to strengthen current data collection activities. Breakout groups were formed around each theme and each group was asked to explore the subject further with an eye to identify concrete action steps or processes that could be employed to address some of the more pressing needs.

A summary of the suggestions generated for these two topics appears below.

Complementary Approach to Research

In addressing the research questions and related gaps, participants generally agreed that some type of organizational framework was needed to ensure that research investments were made in a manner that was both strategic and complementary. Participants then were asked to identify an approach that would facilitate such an outcome. The group coalesced around the following steps to help move the various departments and agencies in this direction:

1. Portfolio analysis – Participants recommended that a more systematic review of existing and current research be conducted and synthesized under general categories such as those found in the IOM/NRC report. This could be useful for identifying other research areas (e.g., those related to criminal justice, mental health, etc.). This information then could be assessed to help identify where sufficient prevention research existed and where research gaps remained. This review also could help ensure new research was complementary or building on the existing knowledge base.
2. Prioritization – Participants also acknowledged that in order for strategic investments to be made some prioritization needed to occur. The framework outlined in the IOM/NRC report could be used as a starting point but additional criteria would need to be developed to help guide priority setting. For instance, participants mentioned elements, such as feasibility and impact, as potential criteria that should be considered.
3. Competitive advantage – Participants noted that the first two items could then be used to engage agencies in further conversation around which department/agencies are best suited to address the priority research questions or areas. This process would seek to align research topics with agency niches and avoid duplication of efforts or mission creep. In addition, this clarification could help agencies guide researchers or potential research activities to the appropriate area.

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Strengthening the Data

Throughout the course of the interviews and the group discussions, three top line actions were deemed necessary as a pathway to strengthening the data:

1. Enhance existing data – making it better and linking it
2. Localize data – creating an infrastructure to facilitate and encourage local usage
3. Standardize data – developing common definitions and data elements

Enhance Existing Data

The first step in this process would be to create an inventory of relevant data sets and data collection systems. As a general point, everyone is aware of numerous existing databases but there is no one group that is aware of all of them. The group felt that the inventory should not only reflect the breadth of available data from different federal and non-federal sources, but also the depth in terms of the characteristics of the data source and specific types of information included within each data source.

In addition to including existing data sources with firearm information, the group mentioned the importance of including other data sets in the inventory that could potentially be augmented to include information on firearms (e.g., to assess the potential of adding questions) to further advance the field.

The ultimate goal is to design a "product" or deliverable that would act as a larger, query-driven database that could be accessible to a wide range of potential users. CDC has initiated work on an inventory, but noted that a collaborative, cross-agency endeavor is needed to make the inventory complete and robust.

In addition to compiling the inventory, the group felt that it was important to assess the completeness of information on firearms within existing systems and consider the feasibility of linking with other sources to improve completeness. Supporting rotations or details to different agencies was seen as a way to fully understand the strengths and limitations of different sources and opportunities for data linkage. Analyzing the same questions across data sets to perform somewhat of a meta-analysis and determine validity of the firearm information could also be useful for improving firearm data.

Localize Data

Apart from identifying local sources of data, there was much discussion of how to make good use of data for prevention purposes. Participants noted the importance of supporting infrastructure at the state and local level to facilitate the use of data for prevention, including identifying inter-agency partnerships that are currently working on the community level and those that might be necessary for success. Local officials want

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information that can be helpful to them; however, there are potential hurdles around data sharing, particularly in cases where there is personally identifiable information.

Given the diverse nature of communities, it is difficult to create a single process, program, or template. Therefore, the group suggested the development of a toolkit that could be used by all communities to offer some modification or customization within a universal structure. The group suggested creating success stories in certain communities as a means to observe and gain insight as well as to promote acceptance and adoption. The idea of creating a federal collaborative parallel with a local/state collaborative was also considered. As a point of potential modeling, the Perinatal Periods of Risk (PPOR) CityMatCH tool and the data collection methodology of the National Collaborative on Childhood Obesity were cited. It was also noted by this group that much of the data gathering and sharing on the local level is for the purpose of developing effective outreach and communications programs.

Standardize Data

This was a very process-oriented discussion dictated by the tactical nature of standardizing definitions and nomenclature in the collection of data. The group recognized a need for common data elements, validated questions, and consistent terminology and measures across survey instruments and data collection efforts. The identified objectives of this overall effort are to facilitate communication through consistency of terms, increase reliability and validity, create opportunities for level comparisons (local/state/federal), enhancing sustainability and creating enduring value and utilization across sectors.

The process to make this happen started with the idea of a formal structure and a multi-stakeholder team. Team/initiative members would come from the areas of law, health, education, policy, and advocacy with the inclusion of practitioners, researchers and representatives from the victim's perspective. The team's first directives would be to agree on goals and development of a statement of purpose. The idea of a stakeholder survey around existing definitions and how they are used in the space of firearm violence was thought to be a reasonable precursor to the first meeting and for identifying interested participants. The group saw this as a very formal project with the end result being a co-branded product with agency logos.

The group suggested that the participants of the federal partner meeting form a task force to develop the initial survey and determine who would receive it. It was suggested that CDC spearhead this initially and then each participating agency would share in the work and hosting of subsequent meetings. The need for shared funding was also acknowledged and the idea of an interagency agreement to support logistics was brought to the table.

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Session 4 – Making It Happen

In the final session, the primary focus was to identify immediate needs for information sharing. While this was somewhat repetitive given the previous conversations, there were some general observations. The participants were primarily focused on developing an approach for information sharing and learning from other collaborative information sharing programs.

A General Accounting Office (GAO) report, *Practices That Can Help Enhance and Sustain Collaboration across Federal Agencies*, points to a number of cross-agency collaborations with common key elements of success including:

1. General outreach
2. Establish schedule for in-person meetings
3. Establish shared goals early in existence and re-visit over time
4. Importance of leadership
5. Leverage existing resources
6. Pilot ideas

The group indicated that it might be helpful to review this report to drive how to approach both information sharing and general collaboration.

The NIH RePORTER (a research query tool), and phConnect (an online collaboration tool for public health professionals) were both cited as models for integrating data and sharing information. More formal mechanisms such as the initiation of federal committees or interagency workgroups also were noted (e.g., the Federal Working Group on Suicide Prevention, Violence Against Women working group, USAID working group on orphans and children).

CLOSING

This report provides a high level summary of the discussions that transpired on February 19-20, 2014, among key federal partners. The report highlights some of the main points raised in regards to current efforts and future opportunities associated with firearm violence prevention research. It also conveys some of the main suggestions made by the meeting participants to address critical components of their collective work. However, the report should not be construed as reflecting the full range of ideas, suggestions, or opportunities generated over the course of the two days. In particular, the forum provided participants with an opportunity to share information about their current firearm violence prevention research, programs, or efforts, and these exchanges helped identify potential areas for improved engagement around this work among various federal agencies. These conversations aren't captured in this report and yet are acknowledged here to demonstrate

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the commitment shown by participants in moving the topic forward. Finally, participants recognized the need to continue conversations and information sharing, be it through informal or formal channels (see discussion above), and its importance in ultimately achieving successful outcomes for firearm violence prevention.

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Appendix A – *Research Discussion Handout*

Priority Topics/Themes

Access to firearms

- Better understanding of background checks/point of purchase denials
- Firearm supply line and its influence on firearm violence
- Better understanding of secondary markets, including online sales, private sales
- Youth and young adult access, possession, carrying
- Understanding of access in other vulnerable populations (children, perpetrators of partner violence, persons with suicidal intentions or who have made a previous attempts)
- Understanding of accessibility of firearms in vulnerable settings such as schools, businesses, and public housing
- Risk and protective factors associated with access
- Influence of access on risk of injuries and deaths
- Influence of access on protection (e.g., defensive gun use) from violence and crime
- Decision-making processes/trade-offs around use of firearms

Technological Approaches

- Technological approaches that are likely to have the greatest impact on firearm violence
- Consumer attitudes toward safety technologies
- Understanding of how compliant consumers would be with different safety technologies
- Understanding of how potential technologies might impact various professional sectors (e.g., police, private security) in performing their duties

Triggers and influences of violence involving firearms

- Role of genetic, neurological or behavioral basis of substance abuse, especially alcohol and drugs in violent events involving firearms
- Mental health factors, including role of stress and prior trauma
- Exposure to violent media
- Situational and contextual factors (e.g., availability of alcohol/drugs, alcohol outlet density, other economic and environmental factors that influence the likelihood of firearm violence)
- Role of environmental design with respect to schools and other settings and its influence on risk for firearm violence

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- Individual factors (e.g., impulsivity, other motivation factors, prior histories of abuse or victimization)
- Linkages between different types of violence (e.g., child maltreatment, intimate partner violence, suicidal behavior) and risk for perpetrating firearm violence

Which intervention strategies, policies, programs prevent firearm violence?

- local, state, and national policies (e.g., background checks; stand your ground laws; child access prevention laws)
- setting-specific strategies (e.g., schools, campuses, workplaces, homes, communities)
- gun safety education programs for children and adults
- counseling and other healthcare provider education programs
- enforcement strategies around prohibited purchasers
- whether existing evidence-based programs for interpersonal or self-directed violence are effective in preventing firearm violence

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Appendix B – *Data Collection Discussion Handout*

Data Gaps Identified

- State-specific population data on firearm use, acquisition, ownership, carrying, and storage practices to assess the effectiveness of firearm injury prevention programs and policies.

- State level data on nonfatal firearm injuries and better national and state level population-based data on the health outcomes of nonfatal firearm injuries (e.g., short and long-term impairment and disability), quality of life measures, and the cost of injury and payer information.

- Better and more complete state and national level population-based data on fatal and nonfatal firearm injury circumstances (e.g., intent of injury, type of firearm used, victim-perpetrator relationship, place of occurrence, work-relatedness, alcohol and drug involvement, gang-related, drug-related, underlying circumstances of the injury incident such as homelessness, financial problems, marital/family/spousal/partner problems, firearm used for self-defense).

- Better population-based data on risk/behavioral factors of firearm injuries (homicide/assault, suicide/intentional self-harm, unintentional) *in the home* (e.g., presence of children in the home, family disputes, alcohol and drug problems, mental health issues, financial problems).

- Better population-based data on risk/behavioral factors of firearm injuries (homicide/assault, suicide/intentional self-harm, unintentional) *outside the home* (e.g., crime-related, drug-related, gang-related, drive-by shooting, sexual violence, intimate partner violence, mental health issues, work-relatedness, joblessness, financial problems, alcohol use during hunting/recreational activities, homelessness).

- Better population-based data on all US school-based fatal and nonfatal firearm injuries (e.g., characteristics of the perpetrator, type of firearm used, source of the weapon and ammunition, emergency response (type of response and timing of response).

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From: Bonzo, Sandra E. (CDC/ONDIEH/OD)
Sent: 17 Mar 2016 12:05:40 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Ikeda, Robin (CDC/ONDIEH/OD)
Subject: FW: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research
Attachments: 2016-03-16 Carper Letter to CDC re gun violence research.pdf

May be a coincidence but compare questions in the attached letter to the questions from Kate Masters in early February.

From: Jones, Kamara (OS/ASPA)
Sent: Tuesday, March 15, 2016 4:00 PM
To: Robinson, Michael J (HHS/ASPA) <michael.robinson@hhs.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; OS - Interviews <interviews@hhs.gov>; Beeton, Jonathan (OS/OASH) <Jonathan.Beeton@hhs.gov>; Broido, Tara (HHS/OASH) <Tara.Broido@hhs.gov>; Gianelli, Diane M (OASH) <Diane.Gianelli@hhs.gov>; Migliaccio, Kate (HHS/OASH) <Kate.Migliaccio@hhs.gov>
Cc: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Bryant, LaKia R. (CDC/OD/OADC) <vuf3@cdc.gov>
Subject: RE: CDC Interview (email) request from The Trace: gun violence DEADLINE: 03-14-16
Do we know the exact date when the piece will be published?
From: Robinson, Michael J (HHS/ASPA)
Sent: Monday, March 14, 2016 6:01 PM
To: Burden, Bernadette (CDC/OD/OADC); OS - Interviews; Beeton, Jonathan (OS/OASH); Broido, Tara (HHS/OASH); Gianelli, Diane M (OASH); Migliaccio, Kate (HHS/OASH)
Cc: Lenard, Courtney (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Bryant, LaKia R. (CDC/OD/OADC)
Subject: Re: CDC Interview (email) request from The Trace: gun violence DEADLINE: 03-14-16
Ok

From: Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>
Sent: Monday, March 14, 2016 5:44:37 PM
To: OS - Interviews; Robinson, Michael J (HHS/ASPA)
Cc: Lenard, Courtney (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Bryant, LaKia R. (CDC/OD/OADC)
Subject: FW: CDC Interview (email) request from The Trace: gun violence DEADLINE: 03-14-16

****

ASPA Media Interview Request Template

****

Reporter: Kate Masters
Organization: The Trace
Phone #(s):
Subject: gun violence
Deadline: 03-14-16
Spokesperson: N/A emailed response only.

Kate Masters with The Trace has a follow up, please see her several previous requests in the thread below in addition the proposed CDC response. Her deadline is today.

From Kate:

Thanks again for all the information about the NVDRS. It was definitely helpful and that piece should be up on our site soon. I'm emailing today because my editors and I are in the drafting phase of my piece on gun violence research at the CDC, and I wanted to let you know that the basis of the story is that the CDC is avoiding the issue of gun violence and bowing to political pressure by essentially foregoing research on firearms, even though there are things the agency could be doing. This is coming from former employees of the CDC, as well as outside gun violence researchers.

I wanted to tell you this so there would be no surprise when the article came out, and also because I wanted to give the CDC a chance to respond to what others are saying. That response could be a statement from you, or I would still love to speak with Dr. Houry directly about the lack of gun research at the Injury Center, but I do recommend addressing these statements somehow so that the CDC's voice is included in the piece.

Proposed Response:

> CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."
>
> The President has requested that CDC conduct research into the causes and prevention of gun violence and the IOM Report noted a number of research areas that might have bipartisan support. CDC is ready to conduct that research if funds are appropriated by Congress.

Thanks in advance,

Bernadette Burden
Senior Public Affairs Specialist
News Media Branch
Division of Public Affairs
CDC/ATSDR
(404)639-3286

From: Robinson, Michael J (HHS/ASPA)
Sent: Friday, February 12, 2016 11:22 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Blackmore, Rebecca (HHS/ASFR) <Rebecca.Blackmore@hhs.gov>; Medvedev, Bree (OS/ASFR) <Bree.Medvedev@hhs.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>; Beeton, Jonathan (OS/OASH) <Jonathan.Beeton@hhs.gov>; Broido, Tara (HHS/OASH) <Tara.Broido@hhs.gov>; Colson, Angela (HHS/OASH) <Angela.Colson@hhs.gov>; Gianelli, Diane M (OASH) <Diane.Gianelli@hhs.gov>; Migliaccio, Kate (HHS/OASH) <Kate.Migliaccio@hhs.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Fine, Amanda

(NIH/OD) [E] <amanda.fine@nih.gov>
Subject: RE: CDC Interview (email) request from The Trace: gun violence
Ok
From: Lenard, Courtney (CDC/ONDIEH/NCIPC) [mailto:zvq5@cdc.gov]
Sent: Friday, February 12, 2016 11:16 AM
To: Robinson, Michael J (HHS/ASPA); Blackmore, Rebecca (HHS/ASFR); Medvedev, Bree (OS/ASFR); Cabezas, Miriam (HHS/ASFR); Beeton, Jonathan (OS/OASH); Broido, Tara (HHS/OASH); Colson, Angela (HHS/OASH); Gianelli, Diane M (OASH); Migliaccio, Kate (HHS/OASH); Cabezas, Miriam (HHS/ASFR)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Dorigo, Leslie (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Burden, Bernadette (CDC/OD/OADC); Fine, Amanda (NIH/OD) [E]
Subject: RE: CDC Interview (email) request from The Trace: gun violence
Good morning,
Deadline is COB today.
Thank you!
Courtney
From: Robinson, Michael J (HHS/ASPA)
Sent: Thursday, February 11, 2016 4:50 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Blackmore, Rebecca (HHS/ASFR) <Rebecca.Blackmore@hhs.gov>; Medvedev, Bree (OS/ASFR) <Bree.Medvedev@hhs.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>; Beeton, Jonathan (OS/OASH) <Jonathan.Beeton@hhs.gov>; Broido, Tara (HHS/OASH) <Tara.Broido@hhs.gov>; Colson, Angela (HHS/OASH) <Angela.Colson@hhs.gov>; Gianelli, Diane M (OASH) <Diane.Gianelli@hhs.gov>; Migliaccio, Kate (HHS/OASH) <Kate.Migliaccio@hhs.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Fine, Amanda (NIH/OD) [E] <amanda.fine@nih.gov>
Subject: RE: CDC Interview (email) request from The Trace: gun violence
Hi –Adding ASFR
What's the deadline for this info?
Best,
From: Lenard, Courtney (CDC/ONDIEH/NCIPC) [mailto:zvq5@cdc.gov]
Sent: Thursday, February 11, 2016 4:48 PM
To: Robinson, Michael J (HHS/ASPA); OS - Interviews; Cabezas, Miriam (HHS/ASFR); Beeton, Jonathan (OS/OASH); Broido, Tara (HHS/OASH); Colson, Angela (HHS/OASH); Gianelli, Diane M (OASH); Migliaccio, Kate (HHS/OASH)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Dorigo, Leslie (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Burden, Bernadette (CDC/OD/OADC); Fine, Amanda (NIH/OD) [E]
Subject: RE: CDC Interview (email) request from The Trace: gun violence
Good afternoon,
Another follow up from Kate with The Trace:
I also know that the President requested the full $23.5 million required to place NVDRS in all 50 states and the District of Columbia in his FY2017 budget request. I asked the White House why that decision was made and why the NVDRS was prioritized this year, and they told me to check with the CDC. So do you guys have any information on why that request was made and why it was important to the administration?
Proposed Response:

The President's budget request for NVDRS has been for $23.5m for several years (since the FY14 request). Expansion of NVDRS to all 50 states and DC has been a priority for the administration since FY14. Although CDC has seen incremental increases (including most recently in FY 16) and will be able to expand the program this year, the FY17 request will allow CDC to expand the program further to truly have a national program (all 50 states and DC).
*NVDRS is the only state-based surveillance system that pools information from multiple data sources into a usable, anonymous data base. It covers all types of violent deaths – including homicides, suicides, and child maltreatment fatalities – in all settings and for all age groups.
Thanks much!
Courtney
From: Robinson, Michael J (HHS/ASPA)
Sent: Thursday, February 04, 2016 4:21 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; OS - Interviews <interviews@hhs.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>; Beeton, Jonathan (OS/OASH) <Jonathan.Beeton@hhs.gov>; Broido, Tara (HHS/OASH) <Tara.Broido@hhs.gov>; Colson, Angela (HHS/OASH) <Angela.Colson@hhs.gov>; Gianelli, Diane M (OASH) <Diane.Gianelli@hhs.gov>; Migliaccio, Kate (HHS/OASH) <Kate.Migliaccio@hhs.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Fine, Amanda (NIH/OD) [E] <amanda.fine@nih.gov>
Subject: RE: CDC Interview (email) request from The Trace: gun violence
Ok
From: Lenard, Courtney (CDC/ONDIEH/NCIPC) [mailto:zvq5@cdc.gov]
Sent: Thursday, February 04, 2016 4:19 PM
To: Robinson, Michael J (HHS/ASPA); OS - Interviews; Cabezas, Miriam (HHS/ASFR); Beeton, Jonathan (OS/OASH); Broido, Tara (HHS/OASH); Colson, Angela (HHS/OASH); Gianelli, Diane M (OASH); Migliaccio, Kate (HHS/OASH)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Dorigo, Leslie (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Burden, Bernadette (CDC/OD/OADC); Fine, Amanda (NIH/OD) [E]
Subject: RE: CDC Interview (email) request from The Trace: gun violence
Good afternoon,
We have a follow up from Kate:
does the CDC still have a "gentleman's agreement" with the gun lobby to report out, to the lobby, any gun research completed by their grantees, whether that research was actually completed with CDC funds or not?
Proposed response, this question came up in the AP interview from a few months ago and this is what we said:
We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out to the NRA in recent years.
Thanks much!
Courtney
From: Robinson, Michael J (HHS/ASPA)
Sent: Wednesday, February 03, 2016 1:27 PM
To: OS - Interviews <interviews@hhs.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>; Beeton, Jonathan (OS/OASH) <Jonathan.Beeton@hhs.gov>; Broido, Tara (HHS/OASH) <Tara.Broido@hhs.gov>; Colson, Angela

(HHS/OASH) <Angela.Colson@hhs.gov>; Gianelli, Diane M (OASH) <Diane.Gianelli@hhs.gov>; Migliaccio, Kate (HHS/OASH) <Kate.Migliaccio@hhs.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Fine, Amanda (NIH/OD) [E] <amanda.fine@nih.gov>
Subject: FW: CDC Interview (email) request from The Trace: gun violence
Ok
(#7 is new)
From: Lenard, Courtney (CDC/ONDIEH/NCIPC) [mailto:zvq5@cdc.gov]
Sent: Wednesday, February 03, 2016 1:05 PM
To: OS - Interviews
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Dorigo, Leslie (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Burden, Bernadette (CDC/OD/OADC); Fine, Amanda (NIH/OD) [E]
Subject: CDC Interview (email) request from The Trace: gun violence
ASPA Media Interview Request
****
Outlet: The Trace
Reporter: Kate Masters
Phone: (571) 643-4275
Subject: gun violence research
Deadline: today
Spokesperson: **email response attributed to Deb Houry**, MD, MPH, director, CDC's Injury Center
Expected place of publication (print, online, broadcast): print
Expected date of publication/airing: n/a
Expected prominence (e.g. front page, Sunday, evening/morning show, etc.): n/a
Background:
FROM KATE: She requested to interview Deb Houry. *"My article is going to be about violence research at the CDC versus the NIH, so most of my questions would center on her approach to running the Center for Injury Control and Prevention, accomplishments she's made, and priorities she'd still like to work on."*
Actual questions:
1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?
3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?
4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?
5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?
7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?
8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

PROPOSED RESPONSE:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached

Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm

Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm

Most recent NVDRS Surveillance Summary:

Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, March 16, 2016 2:18 PM
To: Ikeda, Robin (CDC/ONDIEH/OD) ; Bonzo, Sandra E. (CDC/ONDIEH/OD)
Cc: Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Subject: FW: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Fyi- received today
Opp will begin working on it
Deb Houry, MD, MPH

Director
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
4770 Buford Highway, NE; Mail Stop F63; Atlanta, GA 30341
Twitter: @DebHouryCDC
Phone: (770) 488-4696 || Fax: (770) 488-4222

From: Morris, Dena (CDC/OD/CDCWO)
Sent: Wednesday, March 16, 2016 1:59 PM
To: Frieden, Thomas (Tom) (CDC/OD) <txf2@cdc.gov>; Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Berger, Sherri (CDC/OCOO/OD) <sob8@cdc.gov>; Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>
Subject: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

For your awareness.

RON JOHNSON, WISCONSIN, CHAIRMAN

JOHN McCAIN, ARIZONA
ROB PORTMAN, OHIO
RAND PAUL, KENTUCKY
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United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510–6250

March 16, 2016

Dr. Tom Frieden
Director
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329

Dear Director Frieden:

I write today to request information regarding the Centers for Disease Control and Prevention's (CDC) support for scientific research into the causes and prevention of gun violence.

As the largest collection of public health professionals conducting scientific research for injury prevention in the world, the CDC's National Center for Injury Prevention and Control (Injury Center) has a mission to prevent violence and injuries, and reduce their consequences. Using a public health approach of defining problems, identifying risk factors, and testing prevention strategies, the Injury Center has been at the forefront of identifying scientifically sound solutions to reducing injuries and saving lives.

In the 1990s, the Injury Center played an important role in conducting high-quality, peer-reviewed research into the underlying causes of gun violence. But this changed starting in 1996 when Congress began inserting language into annual spending bills prohibiting the CDC from spending its funds "to advocate or promote gun control."[1] While this language—sponsored by then Representative Jay Dickey—only prohibits the use of funds to support legislative efforts to limit access to firearms, it has often been misconstrued to ban any and all scientific research on gun violence.

As a result, public health researchers at the CDC and other federal agencies have been discouraged from conducting scientific research on gun violence. Although the CDC self-directs a portion of its nearly $6.2 billion annual budget to a wide variety of intra- and extramural research, the CDC has been reluctant to devote funding to gun violence research without a specific appropriation from Congress. Scientists at the CDC have expressed frustration with their inability to conduct more extensive studies on gun violence, which could help to reduce the over 30,000 Americans killed by gun violence each year.[2]

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[1] P.L. 104-208, 110 Stat. 3009-244 (Sep. 30, 1996).

[2] Jess Bidgood, *When Gun Violence Felt Like a Disease, a City in Delaware Turned to the C.D.C.*, NEW YORK TIMES (Dec. 24, 2015).

Encouragingly, recent developments at the CDC have shown that your agency has the ability do more to assist communities that struggle with gun violence.

In my home town of Wilmington, Delaware, the CDC conducted an investigation into elevated levels of gun violence after receiving a request from Wilmington officials and Delaware's Department of Health and Social Services. Released in December 2015, the results of this investigation identified many of the root causes of gun violence in the community and offered recommendations on how prevention and early intervention could reduce violence for those most at risk.[3] In February 2013, the CDC also released the results of an investigation of youth suicide clusters in Delaware's Kent and Sussex counties, finding that 45 percent of suicides between January 2009 and May 2012 were committed using firearms.

I am optimistic that Delaware can benefit from the CDC's work and believe that many other communities across the United States could also benefit from similar scientific research, as well. In a Washington Post op-ed with the Injury Center's former director Mark Rosenberg, Representative Dickey came out in support of additional research, writing that: "…[W]e are in strong agreement now that scientific research should be conducted into preventing firearm injuries and that ways to prevent firearm deaths can be found without encroaching on the rights of legitimate gun owners. The same evidence-based approach that is saving millions of lives from motor-vehicle crashes, as well as from smoking, cancer and HIV/AIDS, can help reduce the toll of deaths and injuries from gun violence."[4]

As a supporter of the Second Amendment to the United States Constitution, I believe that law-abiding citizens have the right to buy and own firearms. I also believe that we can take common sense steps to reduce gun violence. With more than 117,000 Americans injured or killed each year with firearms, conducting scientific research on gun violence is one such step.[5]

Enclosed with this letter is a set of questions and requests for information for your response. I ask that you please respond by April 15, 2016. The Committee's minority staff is authorized to conduct this investigation under the authority of Senate Rule XXV and Senate Resolution 73 (114th Congress). If you or members of your staff have any questions about this request, please feel free to contact Kevin Burris at (202) 224-2627. Thank you for your attention to this matter.

---

[3] Steven Sumner, et. al, *Elevated Rates of Urban Firearm Violence and Opportunities for Prevention—Wilmington, Delaware*, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (Nov. 3, 2015).

[4] Jay Dickey and Mark Rosenberg, *How to Protect Gun Rights While Reducing the Toll of Gun Violence*, WASHINGTON POST (Dec. 25, 2015).

[5] Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS), *Fatal and Nonfatal Injury Reports* (2013).

With best personal regards, I am

Sincerely yours,

Thomas R. Carper

Thomas R. Carper
Ranking Member

Enclosure

cc: The Honorable Ron Johnson
Chairman

Questions for Dr. Tom Frieden
Director, Centers for Disease Control and Prevention

1. Please describe the CDC's policy toward scientific research into the causes and prevention of gun violence.

2. Has the CDC or the Department of Health and Human Services' Office of the General Counsel conducted any analysis of the Dickey Amendment, including the types of gun violence research that are still permissible? If so, please provide this analysis.

3. In the aftermath of the shooting at Sandy Hook Elementary School in December 2012, President Obama issued a memorandum directing the Secretary of Health and Human Services (HHS), through the Director of the CDC and other agencies within HHS, to conduct or sponsor research into the causes of gun violence and the ways to prevent it.[6] Please describe the efforts CDC has taken in response to this memorandum.

4. In April 2013, the National Center for Injury Prevention and Control asked the Institute of Medicine to recommend a research agenda on the public health aspects of firearm-related violence.[7] Please describe the actions the CDC plans to take in response to the findings of the Institute of Medicine report issued in June 2013.

5. From 1996 to the present, please describe notable examples of research conducted or funded by the CDC, including research by or through the National Center for Injury Prevention and Control, related to understanding gun violence. Please also provide all instances when the CDC included requests for gun violence research in its research proposal solicitation materials.

6. For each year from FY1996 to FY2015, what portion of the CDC's budget, including the budget of the National Center for Injury Prevention and Control, has been devoted to gun violence research?

7. Each year, CDC's Division of Violence Prevention solicits investigator-initiated research via an "R01" Grant Program Announcement. The language in these announcements signals to grant-seeking public health researchers the research priorities of the CDC and its Division of Violence Prevention. Please describe any Division of Violence Prevention's R01 Grant Program Announcements related to gun violence research put forward from 1996 to the present.

---

[6] Presidential Memorandum – Engaging in Public Health Research on the Causes and Prevention of Gun Violence (Jan. 16, 2013).

[7] *New Report Identifies Research Priorities for Most Pressing Gun Violence Problems in U.S.*, National Academies of Sciences, Engineering, and Medicine (June 5, 2013).

8. The National Violent Death Reporting System collects and combines data from multiple sources to provide states and communities with a more complete record of the circumstances surrounding violent deaths. Participation from all 50 states would significantly increase the amount of data available to the National Violent Death Reporting System and, thereby, improve its effectiveness. In how many states has the National Violent Death Reporting System been implemented? How many states have applied to be included in this system? What circumstances have prevented all state applicants from being added to the National Violent Death Reporting System?

9. Has the CDC previously entered into any agreements with the National Rifle Association offering to provide advanced notice of any publication on the subject of gun violence? If so, please provide a description of any such agreements as well as communications and documents memorializing the agreements.

10. From 1996 to the present, has the CDC instructed any employee or researcher to not conduct scientific research on gun violence? Has the CDC instructed any employees or researchers to re-write reports submitted for publication to avoid using any variation of the word "gun"?

11. What remedies are available to CDC researchers who believe their scientific research has been inappropriately suppressed or discouraged? Please describe any review or appeals processes and include a list of the offices or review boards who would address any such concerns.

From: aec1@cdc.gov
Sent: 6 Apr 2016 19:16:17 -0400
To: Blair, Janet (CDC/ONDIEH/NCIPC);Hall, Jeffrey (CDC/ONDIEH/NCIPC);Kress, Howard (CDC/ONDIEH/NCIPC)
Cc: Frazier, Leroy Jr. (CDC/ONDIEH/NCIPC)
Subject: Fw: Over 100 orgs sign letter to Congress re: CDC/gun research
Attachments: CDC_letter_4-6_FINAL.pdf
Importance: High

Greetings:
In case you hadn't rec'd this msg.
Alex C

Sent from my BlackBerry 10 smartphone.
From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 6, 2016 08:51
To: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Subject: Fw: Over 100 orgs sign letter to Congress re: CDC/gun research

Sent from my BlackBerry 10 smartphone.
From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 6, 2016 8:08 AM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC); Peeples, Amy B. (CDC/ONDIEH/NCIPC); Connelly, Erin (CDC/ONDIEH/NCIPC); Patterson, Sara S. (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Lenard, Courtney (CDC/ONDIEH/NCIPC); Reimels, Elizabeth (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Burton, Tessa (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: Over 100 orgs sign letter to Congress re: CDC/gun research

Not sure who all is around this week or checking BB while out, but wanted to share this around…

Public health groups urge Congress to allow funding of gun control research

Nearly 150 public health organizations — including heavy hitters like the American Medical Association, Doctors for America, and AAAS — have sent a letter to Congress this morning urging lawmakers to end restrictions on gun violence research. The CDC has been banned from funding research that might promote gun control since 1996.
http://files.www.drsforamerica.org/blog/blogs-from-dc-climate-change-and-health-at-the-white-house/CDC_letter_4-6_FINAL.pdf
Full letter attached/at link, and pasted below for those on BB.
April 6, 2016

The Honorable Thad Cochran
Chairman, Appropriations Committee
U.S. Senate
Washington, DC 20515
The Honorable Barbara Mikulski
Vice Chairwoman, Appropriations Committee
U.S. Senate
Washington, DC 20515
The Honorable Harold Rogers
Chairman, Appropriations Committee
U.S. House of Representatives
Washington, DC 20515
The Honorable Nita Lowey
Ranking Member, Appropriations Committee
U.S. House of Representatives
Washington, DC 20515
Dear Senator/Representative:

The undersigned health care, public health, scientific organizations and research universities representing over 1 million members across the country **urge you to end the dramatic chilling effect of the current rider language restricting gun violence research and to fund this critical work at the Centers for Disease Control and Prevention (CDC).**

In 1996, Congress passed the so-called Dickey amendment as a rider to the Labor-Health and Human Services-Education Appropriations bill. The language stated that the CDC could not fund research that would "advocate or promote gun control," and the language has remained in each subsequent annual funding bill. At the same time, Congress cut CDC funding for this research. Although the Dickey amendment does not explicitly prevent research on gun violence, the combination of these two actions has caused a dramatic chilling effect on federal research that has stalled and stymied progress on gathering critical data to inform prevention of gun violence for the past 20 years. Furthermore, it has discouraged the next generation of researchers from entering the field.

Gun violence is a serious public health epidemic resulting in the senseless deaths of an average of 91 Americans, and another 108 gun injuries, each and every day. A central part of preventing future tragedies is through conducting rigorous scientific research as this has been a proven successful approach in reducing deaths due to other injuries.

Health care providers and public health professionals are overwhelmed in emergency departments, clinics, offices, and communities with the victims of mass shootings, homicides, suicides, accidental shootings, and firearm injuries. Medical professionals and our communities work to address the devastating and long-lasting physical and emotional effects of gun violence on victims, their families and their friends, but are hampered by the insufficient body of evidence-based research to use to point communities toward proven gun violence prevention programs and policies.

Former Representative Jay Dickey (R-AR), author of the current language that has effectively restricted gun violence research, recently noted that, "it is my position that somehow or someway we should slowly but methodically fund [gun] research until a solution is reached. Doing nothing is no longer an acceptable solution."

Here are some of the critical questions that enhanced research would help us answer:
1) **What is the best way to protect toddlers from accidentally firing a firearm?** Safe firearm storage works, but what kinds of campaigns best encourage safe storage? What safe storage methods are the most effective and most likely to be adopted? What should be the trigger pull on a firearm so a toddler can't use it?
2) **What are the most effective ways to prevent gun-related suicides?** Two-thirds of firearm related deaths are suicides. Are firearm suicides more spontaneous than non-firearm suicides? Do other risk factors vary by method? How do we prevent it in different populations—active military, veterans, those with mental illness, law enforcement or correctional officers, the elderly, or teenagers?
3) **What is the impact of the variety of state policies being enacted?** How are different policies around safe storage, mental health, public education, and background checks impacting firearm injuries and deaths?
The CDC's National Center for Injury Prevention and Control is an important part of answering these types of questions. Public health uniquely brings together a comprehensive approach connecting the complex factors that result in violence and injuries including clinical, social, criminal, mental health, and environmental factors. The impact of federal public health research in reducing deaths from car accidents, smoking and Sudden Infant Death Syndrome has been well proven. Decades ago, we did not know infant car seats should be rear-facing. Robust research on car accidents and subsequent legislation has helped save hundreds of thousands of lives without preventing people from being able to drive. It's time to apply the same approach to reducing gun violence in our communities.
As professionals dedicated to the health of the nation and to the application of sound science to improving the lives of our fellow Americans, we urge you to take action this year. Americans deserve to know that we are working with the best tools and information in the fight to reduce gun violence deaths and injuries.
As Congress works to craft the FY 2017 Labor-HHS-Education Appropriations bill, we urge you to provide the Centers for Disease Control and Prevention with funding for research into the causes and prevention of gun violence.
Thank you for your consideration. We look forward to working with you to improve health and protect the safety of all Americans.
Sincerely,
Academic Consortium for Integrative Medicine & Health Academic Pediatric Association Alameda Health System Department of Emergency Medicine American Academy of Family Physicians American Academy of Pediatrics American Association for the Advancement of Science American Association of Colleges of Pharmacy American Association of Nurse Practitioners American College of Emergency Physicians American College of Emergency Physicians, California Chapter American College of Occupational and Environmental Medicine American College of Physicians American Congress of Obstetricians and Gynecologists American Educational Research Association American Geriatrics Society American Medical Association American Medical Student Association American Medical Women's Association American Pediatric Society American Psychiatric Association American Psychological Association American Public Health Association American Society for Clinical Pathology American Society of Hematology American Thoracic Society American Trauma Society Arkansas Public Health Association Asociación de Salud Pública de Puerto Rico Association for Psychological Science Association of

American Universities Association of Medical School Pediatric Department Chairs Association of Population Centers Association of Public and Land-grant Universities Big Cities Health Coalition Boulder County Public Health Brigham Psychiatric Specialties California Center for Public Health Advocacy California Public Health Association-North Center for Science and Democracy at the Union of Concerned Scientists Central Oregon Medical Society Champaign-Urbana Public Health District Chicago Center for Psychoanalysis Chicago chapter Physicians for Social Responsibility Colorado Public Health Association Committee of Interns and Residents/SEIU Healthcare Congregation Gates of Heaven

Consortium of Social Science Associations Council of State and Territorial Epidemiologists Cure Violence Delaware Academy of Medicine / Delaware Public Health Association Doctors Council SEIU Doctors for America Eastern Association for the Surgery of Trauma Federation of Associations in Behavioral and Brain Sciences Florida Chapter of the American Academy of Pediatrics, Inc. Futures Without Violence Georgia Public Health Association Hawaii Public Health Association Health Officers Association of California Houston Health Department Illinois Public Health Association International Society for Developmental Psychobiology Iowa Chapter Physicians for Social Responsibility Iowa Public Health Association JPS Health Network Kansas Public Health Association Koop Institute KU Department of Preventive Medicine and Public Health Law and Society Association Lee County Health Department Local Public Health Association of Minnesota Louisiana Center for Health Equity Maine Public Health Association Maryland Academy of Family Physicians Minnesota Public Health Association Montana Public Health Association National AHEC Organization National Association of County and City Health Officials National Association of Medical Examiners National Association of Nurse Practitioners in Women's Health National Association of Social Workers National Association of State Emergency Medical Services Officials National Association of State Head Injury Administrators National Black Nurses Association National Hispanic Medical Association National Medical Association National Network of Public Health Institutes National Physicians Alliance National Violence Prevention Network Nevada Public Health Association

New Hampshire Public Health Association New Mexico Public Health Association North Carolina Public Health Association Ohio Public Health Association Ohio Public Health Association Oregon Academy of Family Physicians Oregon Physicians for Social Responsibility Oregon Public Health Association Pediatric Policy Council Physicians for Social Responsibility, Arizona Chapter Physicians for a National Health Program NY Metro Chapter Physicians for Reproductive Health Physicians for Social Responsibility / Northeast Ohio Physicians for Social Responsibility Wisconsin Physicians for Social Responsibility, Arizona Chapter Physicians for Social Responsibility/New York Physicians for the Prevention of Gun Violence Population Association of America Prevention Institute Psychonomic Society Public Health Association of Nebraska Public Health Association of New York City Public Health Institute Research!America RiverStone Health Safe States Alliance San Francisco Bay Area Chapter, Physicians for Social Responsibility Society for Adolescent Health and Medicine Society for Advancement of Violence and Injury Research Society for Mathematical Psychology Society for Pediatric Research Society for Psychophysiological Research Society for Public Health Education Society of Experimental Social Psychology Society of General Internal Medicine Southern California Public Health Association Southwest Ohio Society of Family Medicine Student National Medical Association Suicide Awareness Voices of Education Texas Doctors for Social Responsibility Texas Public Health Association Trauma Foundation Tri-County Health Department Trust for America's Health

United Physicians of Newtown Vermont Public Health Association Virginia Public Health Association Washington Chapter of the American Academy of Pediatrics Washington State Public Health Association Wellness Institute of Greater Buffalo Whiteside County Health Department

cc:

The Honorable Mitch McConnell
The Honorable Paul Ryan
The Honorable Harry Reid
The Honorable Nancy Pelosi Members of Congress

April 6, 2016

The Honorable Thad Cochran
Chairman, Appropriations Committee
U.S. Senate
Washington, DC 20515

The Honorable Harold Rogers
Chairman, Appropriations Committee
U.S. House of Representatives
Washington, DC 20515

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Vice Chairwoman, Appropriations Committee
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Ranking Member, Appropriations Committee
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Washington, DC 20515

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As Congress works to craft the FY 2017 Labor-HHS-Education Appropriations bill, we urge you to provide the Centers for Disease Control and Prevention with funding for research into the causes and prevention of gun violence.

Thank you for your consideration. We look forward to working with you to improve health and protect the safety of all Americans.

Sincerely,

Academic Consortium for Integrative Medicine & Health
Academic Pediatric Association

Alameda Health System Department of Emergency Medicine
American Academy of Family Physicians
American Academy of Pediatrics
American Association for the Advancement of Science
American Association of Colleges of Pharmacy
American Association of Nurse Practitioners
American College of Emergency Physicians
American College of Emergency Physicians, California Chapter
American College of Occupational and Environmental Medicine
American College of Physicians
American Congress of Obstetricians and Gynecologists
American Educational Research Association
American Geriatrics Society
American Medical Association
American Medical Student Association
American Medical Women's Association
American Pediatric Society
American Psychiatric Association
American Psychological Association
American Public Health Association
American Society for Clinical Pathology
American Society of Hematology
American Thoracic Society
American Trauma Society
Arkansas Public Health Association
Asociación de Salud Pública de Puerto Rico
Association for Psychological Science
Association of American Universities
Association of Medical School Pediatric Department Chairs
Association of Population Centers
Association of Public and Land-grant Universities
Big Cities Health Coalition
Boulder County Public Health
Brigham Psychiatric Specialties
California Center for Public Health Advocacy
California Public Health Association-North
Center for Science and Democracy at the Union of Concerned Scientists
Central Oregon Medical Society
Champaign-Urbana Public Health District
Chicago Center for Psychoanalysis
Chicago chapter Physicians for Social Responsibility
Colorado Public Health Association
Committee of Interns and Residents/SEIU Healthcare
Congregation Gates of Heaven

Consortium of Social Science Associations
Council of State and Territorial Epidemiologists
Cure Violence
Delaware Academy of Medicine / Delaware Public Health Association
Doctors Council SEIU
Doctors for America
Eastern Association for the Surgery of Trauma
Federation of Associations in Behavioral and Brain Sciences
Florida Chapter of the American Academy of Pediatrics, Inc.
Futures Without Violence
Georgia Public Health Association
Hawaii Public Health Association
Health Officers Association of California
Houston Health Department
Illinois Public Health Association
International Society for Developmental Psychobiology
Iowa Chapter Physicians for Social Responsibility
Iowa Public Health Association
JPS Health Network
Kansas Public Health Association
Koop Institute
KU Department of Preventive Medicine and Public Health
Law and Society Association
Lee County Health Department
Local Public Health Association of Minnesota
Louisiana Center for Health Equity
Maine Public Health Association
Maryland Academy of Family Physicians
Minnesota Public Health Association
Montana Public Health Association
National AHEC Organization
National Association of County and City Health Officials
National Association of Medical Examiners
National Association of Nurse Practitioners in Women's Health
National Association of Social Workers
National Association of State Emergency Medical Services Officials
National Association of State Head Injury Administrators
National Black Nurses Association
National Hispanic Medical Association
National Medical Association
National Network of Public Health Institutes
National Physicians Alliance
National Violence Prevention Network
Nevada Public Health Association

New Hampshire Public Health Association
New Mexico Public Health Association
North Carolina Public Health Association
Ohio Public Health Association
Ohio Public Health Association
Oregon Academy of Family Physicians
Oregon Physicians for Social Responsibility
Oregon Public Health Association
Pediatric Policy Council
Physicians for Social Responsibility, Arizona Chapter
Physicians for a National Health Program NY Metro Chapter
Physicians for Reproductive Health
Physicians for Social Responsibility / Northeast Ohio
Physicians for Social Responsibility Wisconsin
Physicians for Social Responsibility, Arizona Chapter
Physicians for Social Responsibility/New York
Physicians for the Prevention of Gun Violence
Population Association of America
Prevention Institute
Psychonomic Society
Public Health Association of Nebraska
Public Health Association of New York City
Public Health Institute
Research!America
RiverStone Health
Safe States Alliance
San Francisco Bay Area Chapter, Physicians for Social Responsibility
Society for Adolescent Health and Medicine
Society for Advancement of Violence and Injury Research
Society for Mathematical Psychology
Society for Pediatric Research
Society for Psychophysiological Research
Society for Public Health Education
Society of Experimental Social Psychology
Society of General Internal Medicine
Southern California Public Health Association
Southwest Ohio Society of Family Medicine
Student National Medical Association
Suicide Awareness Voices of Education
Texas Doctors for Social Responsibility
Texas Public Health Association
Trauma Foundation
Tri-County Health Department
Trust for America's Health

United Physicians of Newtown
Vermont Public Health Association
Virginia Public Health Association
Washington Chapter of the American Academy of Pediatrics
Washington State Public Health Association
Wellness Institute of Greater Buffalo
Whiteside County Health Department

cc:
The Honorable Mitch McConnell
The Honorable Paul Ryan
The Honorable Harry Reid
The Honorable Nancy Pelosi
Members of Congress

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: 16 Jun 2016 14:48:15 +0000
To: Patterson, Sara S. (CDC/ONDIEH/NCIPC);Amy B. Peeples (CDC/ONDIEH/NCIPC) (asb0@cdc.gov)
Subject: FW: Schatz key take aways if helpful for tomorrow for Dr Frieden

Fyi- I mentioned this to amy already-
Will fill you in too sara about larger issue
Deb Houry, MD, MPH
Director
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
4770 Buford Highway, NE; Mail Stop F63; Atlanta, GA 30341
Twitter: @DebHouryCDC
Phone: (770) 488-4696 || Fax: (770) 488-4222



From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 15, 2016 8:47 PM
To: Foti, Kathryn (CDC/OD/OCS) ; Morris, Dena (CDC/OD/CDCWO)
Subject: Schatz key take aways if helpful for tomorrow for Dr Frieden

Met with Aimee his health LA- she's a pediatrician so gets public health/ injury prevention
Falls- big interest of the Senator- they had been briefed by American College of Prev Med re the CPT code we have been working with them on- this CPT code was recently rejected by AMA- we will be resubmitting this month. They may be interested in sending letter of support to AMA re this (of note, HI has one of the lowest rates of falls in US- has good community based Tai Chi program)
Suicide- advocates recently met with them- I mentioned the FY17 request and what our vision for work in suicide would be (community level interventions in states and tribal communities; implementing evidence based approaches; expanding NVDRS nationally)- she said they are extremely interested in suicide and would like to support our efforts
FV- she brought this up esp with AMA resolution this week re lifting Dickey amendment. I talked about the work we were doing (child injury papers, optional BRFSS module, ICRC projects) but talked about the importance of report language and/ or appropriation. She wants to have a follow up discussion on this to see how they can help move this forward

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: 19 Apr 2016 08:02:52 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Subject: FW: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690
Attachments: 2353690 Carper Response- Gun Violence Draft v5 (003).docx

Deb,

(b)(5)

Jim

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, April 18, 2016 9:48 AM
To: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC)
Cc: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) ; Patterson, Sara S. (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: FW: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

Hello! This is looking really good, but we have some concerns about some of the edits that were made.

(b)(5)

(b)(5)

Can we still provide feedback on this version? Thanks!

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, April 18, 2016 9:02 AM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: FW: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690
From: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, April 18, 2016 8:15 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; DVP Policy Requests (CDC) <dvppolicyrequests@cdc.gov>
Cc: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>; Patterson, Sara S. (CDC/ONDIEH/NCIPC) <afo0@cdc.gov>; Asekun, Adeyelu (CDC/ONDIEH/NCIPC) <fpg8@cdc.gov>
Subject: FYI: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

FYI...this is the latest, final or very near final.

From: Hoffmann, Lauren (CDC/OD/OCS)
Sent: Monday, April 18, 2016 8:04 AM
To: Lubar, Debra (CDC/OCOO/OFR/OA) <dpl9@cdc.gov>; Patterson, Sara S. (CDC/ONDIEH/NCIPC) <afo0@cdc.gov>
Cc: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Subject: FW: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690
Importance: High

Deb —I think Dr. Frieden is waiting for you to say that you are OK with the response for #6 and then he will clear. It was the only concern/question that he raised.
Sara—Attached is what we expect to be the final.
Lauren

Lauren Hoffmann, MA, BS I Lead, High Profile Action Team, Division of Issues Management, Analysis and Coordination (IMAC) I Office of Chief of Staff I Office of the Director I Centers for Disease Control and Prevention
1600 Clifton Road, NE, Atlanta, GA 30333 I Office: 404-639-7126 I Mobile: 404-547-3997 I E-mail: cpf5@cdc.gov
Forecast. Coordinate. Communicate.

From: Frieden, Thomas (Tom) (CDC/OD)
Sent: Friday, April 15, 2016 6:13 PM
To: Payne, Rebecca L. (CDC/OD/OCS) <rco0@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>; Lubar, Debra (CDC/OCOO/OFR/OA) <dpl9@cdc.gov>
Subject: RE: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

I'm ok w it if Deb is

From: Payne, Rebecca L. (CDC/OD/OCS)
Sent: Friday, April 15, 2016 5:03 PM
To: Frieden, Thomas (Tom) (CDC/OD) <txf2@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>; Lubar, Debra (CDC/OCOO/OFR/OA) <dpl9@cdc.gov>
Subject: RE: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

(b)(5)

+Deb in case this raises additional questions

From: Payne, Rebecca L. (CDC/OD/OCS)
Sent: Friday, April 15, 2016 4:47 PM
To: Frieden, Thomas (Tom) (CDC/OD) <txf2@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>
Subject: RE: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

The appendices are in the end of the word doc but pasted the full doc below as well – we are checking on the funding q

The Honorable Thomas R. Carper
Ranking Member, Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Senator Carper:

Thank you for your letter regarding the status of the Centers for Disease Control and Prevention's (CDC) research into the causes and prevention of gun violence. CDC appreciates your concerns and those of the Committee on Homeland Security and Governmental Affairs, and is committed to protecting the health, safety, and security of the American people.

Enclosed, please find detailed responses to the specific questions outlined in your letter. We appreciate the Committee's interest in this important public health issue.

If you have additional questions or concerns, please contact Cristi Schwarcz in the CDC Washington Office at Cschwarcz@cdc.gov or (202) 245-0600.

Sincerely,

Thomas R. Frieden, MD, MPH
Director, CDC
Enclosure

Centers for Disease Control and Prevention (CDC) Response to the Senate Committee on Homeland Security and Governmental Affairs regarding Gun Violence Research

1. **Please describe the CDC's policy toward scientific research into the causes and prevention of gun violence.**

(b)(5)

2. **Has the CDC or the Department of Health and Human Services' (HHS) Office of the General Counsel conducted any analysis of the Dickey Amendment, including the types of gun violence research that are still permissible? If so, please provide this analysis.**

(b)(5)

(b)(5)

3. **In the aftermath of the shooting at Sandy Hook Elementary School in December 2012, President Obama issued a memorandum directing the Secretary of Health and Human Services (HHS), through the Director of the CDC and other agencies within HHS, to conduct or sponsor research into the causes of gun violence and the ways to prevent it. Please describe the efforts CDC has taken in response to this memorandum.**

(b)(5)

(b)(5)

(b)(5)

(b)(5)

4. In April 2013, the National Center for Injury Prevention and Control asked the Institute of Medicine to recommend a research agenda on the public health aspects of firearm-related violence. Please describe the actions the CDC plans to take in response to the findings of the Institute of Medicine report issued in June 2013.

(b)(5)

(b)(5)

5. **From 1996 to the present, please describe notable examples of research conducted or funded by the CDC, including research by or through the National Center for Injury Prevention and Control, related to understanding gun violence.**

(b)(5)

5a. Please also provide all instances when the CDC included requests for gun violence research in its research proposal solicitation materials.

(b)(5)

6. **For each year from FY1996 to FY2015, what portion of the CDC's budget, including the budget of the National Center for Injury Prevention and Control, has been devoted to gun violence research?**

(b)(5)

7. **Each year, CDC's Division of Violence Prevention solicits investigator-initiated research via an "RO1" Grant Program Announcement. The language in these announcements signals to grant-seeking public health researchers the research priorities of the CDC and its Division of Violence Prevention. Please describe any Division of Violence Prevention's RO1 Grant Program Announcements related to gun violence research put forward from 1996 to the present.**

(b)(5)

(b)(5)

8. **The National Violent Death Reporting System collects and combines data from multiple sources to provide states and communities with a more complete record of the circumstances surrounding violent deaths. Participation from all 50 states would significantly increase the amount of data available to the National Violent Death Reporting System and, thereby, improve its effectiveness. In how many states has the National Violent Death Reporting System been implemented?**

(b)(5)

(b)(5)

8a. How many states have applied to be included in this system?

(b)(5)

8b. What circumstances have prevented all state applicants from being added to the National Violent Death Reporting System?

(b)(5)

9. Has the CDC previously entered into any agreements with the National Rifle Association offering to provide advanced notice of any publication on the subject of gun violence? If so, please provide a description of any such agreements as well as communications and documents memorializing the agreements.

(b)(5)

10. From 1996 to the present, has the CDC instructed any employee or researcher to not conduct scientific research on gun violence? Has the CDC instructed any employees or researchers to re-write reports submitted for publication to avoid using any variation of the word "gun"?

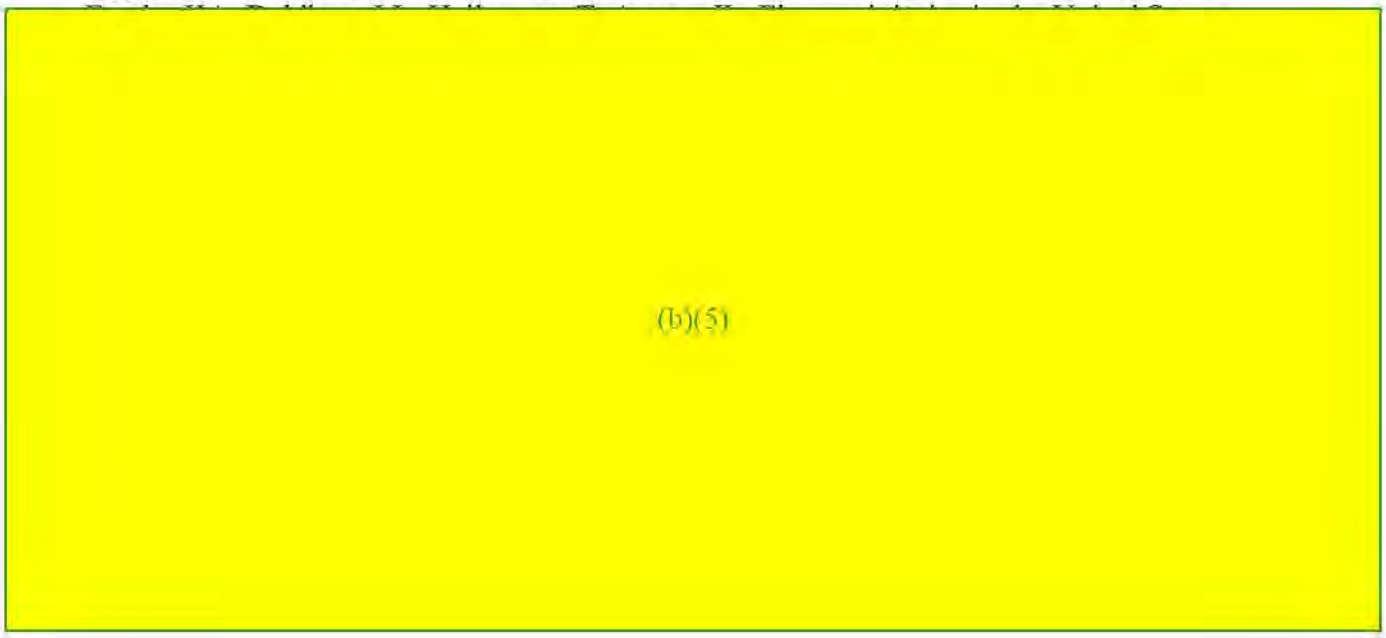
(b)(5)

(b)(5)

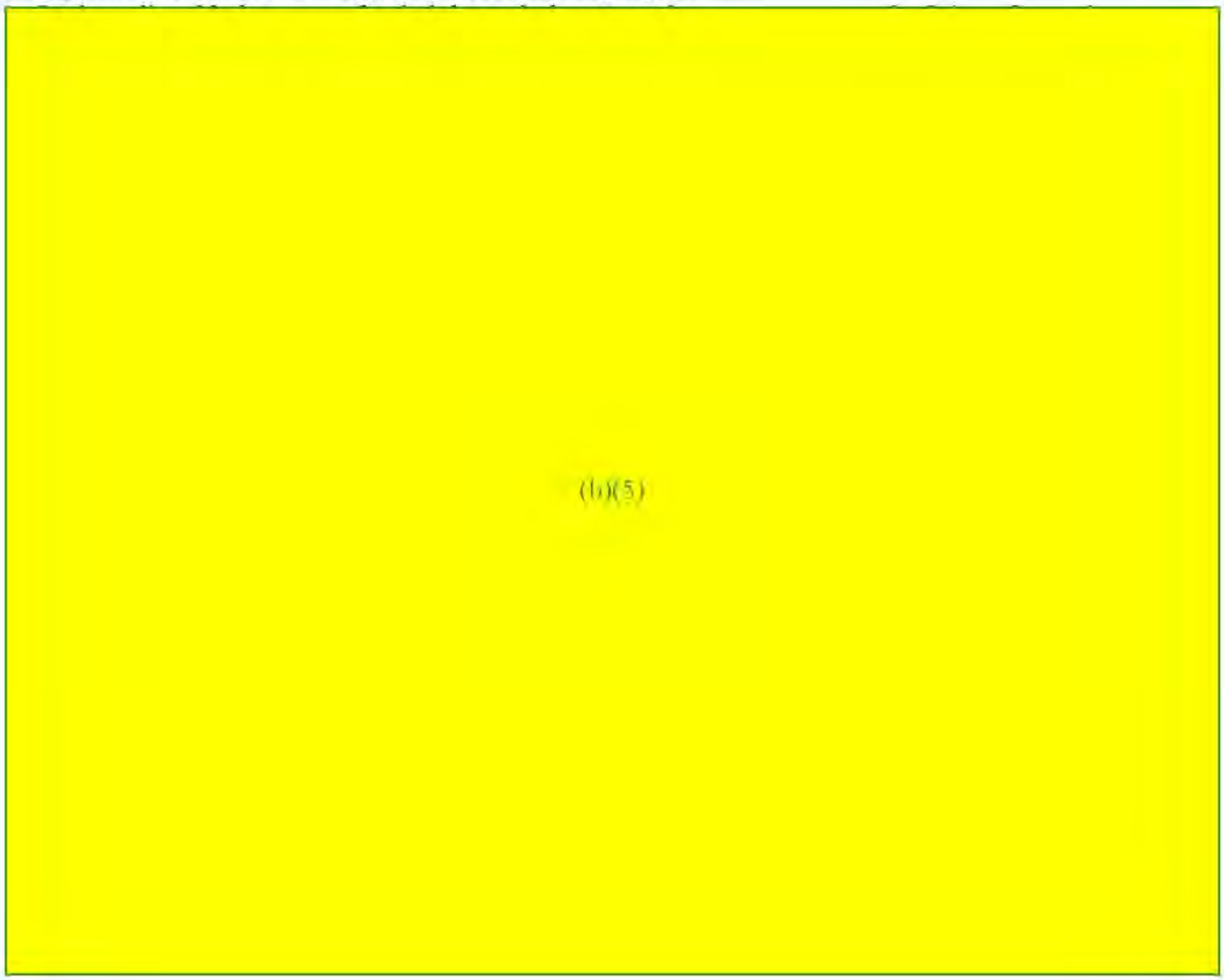
11. **What remedies are available to CDC researchers who believe their scientific research has been inappropriately suppressed or discouraged? Please describe any review or appeals processes and include a list of the offices or review boards who would address any such concerns.**

(b)(5)

Appendix A – Examples of CDC firearm-related surveillance activities and analyses



Appendix B – CDC firearm-related research projects



Appendix C – Research solicitations

(b)(5)

1996

FOA# CE96-011 Grants for Violence-Related Injury Prevention Research

Grant applicants should concentrate on the need to reduce morbidity, mortality, and disabilities caused by suicidal behavior, assaultive behavior among youth, and family and intimate partner violence.

1. Injury from Suicidal and Assaultive Behavior

Enhancing our understanding of social, economic, and environmental factors that may affect suicidal behavior:

- Study how choice of method (firearm, overdosing, etc.) in planning or attempting suicidal behavior is influenced by cultural, social, or environmental factors.
- Conduct research to determine the nature of suicide risk among gay and lesbian persons in comparison to the general population.
- Evaluate policies, programs, or interventions that may reduce suicidal behavior via the modification of social, economic, or environmental circumstances.
- Assess the effectiveness of interventions that attempt to remove access to lethal means in reducing injury and severity of injury from suicidal behavior.

Enhancing our understanding of the importance of social and economic factors that influence assaultive behavior among youth:

- Study why many socioeconomically disadvantaged youth do not engage in assaultive behavior despite their socioeconomic status.
- Undertake research to increase our understanding of relationships between poverty and assaultive behavior among youth.
- Study how unequal access to criminal justice, health care, and educational systems is related to assaultive behavior.
- Evaluate policies, programs, or interventions that may reduce assaultive behavior among youth via the modification of social or economic circumstances.

2. Family and Intimate Violence Prevention

Address and define the needs of mothers and children in families where intimate violence occurs.

- Undertake research to determine effective interventions for mothers and children in families with ongoing violence
- Conduct studies to determine which mothers and children are most likely to be helped by interventions designed for families with ongoing violence
- Examine variables related to mothers, children, and families that may predict intervention effectiveness
- Conduct studies related to the impact of children witnessing violence in their families.

Define the incidence or prevalence of functional limitations and disabilities among women as a result of intimate partner violence.

- Quantify injuries sustained (nature and severity) and subsequent short and long-term (1-year) functional limitations and disability
- Quantify the use of acute care, mental health, rehabilitation, and social services

- Identify risk factors for adverse outcomes

1998

FOA# CE98-029 Grants for Violence-Related Injury Prevention Research

Grant applicants should concentrate on the need to reduce morbidity, mortality, and disabilities caused by suicidal behavior, firearm-related injury, sexual violence, or intimate partner violence.

1. *Injury prevention research addressing emerging issues in suicidal behavior*
   - Conduct research to develop and improve measurement instruments for the identification and study of suicides and suicide attempts in surveys, research studies, and surveillance systems.
   - Conduct research designed to improve understanding of the nature of suicide risk among emerging high-risk populations such as young African American males.
   - Conduct research that further illuminates understanding of the contribution of potential risk factors for suicide such as impulsivity, sexual orientation, and hopelessness.
2. *Injury prevention research addressing firearm-related injuries among children and adolescents*
   - Conduct research to improve understanding of the motivations and deterrents for weapon carrying behavior among adolescents at high risk for firearm-related injuries.
   - Conduct research that estimates injury risk associated with firearm storage or carriage practices.
   - Conduct research that addresses the effects of firearm safety training and education programs on firearm storage and carriage practices.
3. *Injury prevention research addressing sexual violence or intimate partner violence*
   - Conduct research to address the impact of welfare and welfare-to-work programs on women (and their children) who experience intimate partner violence.
   - Conduct research to determine the effectiveness of prevention programs for adolescent males at risk for perpetration of sexual violence or intimate partner violence or intervention programs for perpetrators of sexual violence or intimate partner violence.
   - Conduct research on risk factors for perpetration of sexual violence.

1999

FOA# CE99-055 Extramural Grants for Violence-Related Injury Evaluation Research

The purposes of this program are to: evaluate the effectiveness and/or cost effectiveness of interventions and policies designed to reduce morbidity, mortality, and disabilities caused by suicidal behavior, firearm-related injury, sexual violence, or intimate partner violence.

1. In the area of suicide, there is particular interest in projects to evaluate suicide prevention interventions for general or high risk populations and projects to evaluate services provided in various settings such as a managed care setting.
2. In the area of firearm injuries, there is particular interest in projects evaluating prevention programs and policies that offer promise in preventing firearm injuries among children and adolescents (e.g., safe storage of firearms in homes, safe gun technology, curricula to promote gun safety for children and adolescents).

3. In the areas of sexual violence and intimate partner violence, there is particular interest in evaluation research to determine the effectiveness of:
    - Prevention programs for adolescent males at risk for perpetration of sexual violence or intimate partner violence; or
    - Intervention programs for perpetrators of sexual violence or intimate partner violence.

2001

FOA# CE01-016 Grants for Violence-Related Injury Prevention Research

Research is sought to better understand the etiology of violence and its consequences, to determine how best to prevent violence-related injury among different segments of the population and in different settings, and how best to reduce the severity of the emotional and physical consequences of violence.

1. *Improve understanding of the etiology of violence (i.e., interpersonal youth violence, child abuse, intimate partner violence, suicide, and sexual assault) and its consequences through research that addresses:*
    - The independent, additive, interactive, and sequential effects of psychological, socioeconomic, and environmental risk and protective factors.
    - Factors that have differential effects on the onset, persistence, escalation, de-escalation, or desistance of violent offending at different ages.
    - Factors that increase the severity of the emotional and physical consequences of violence and suicidal behavior.
    - The effect of social and economic risk and protective factors such as poverty, social contagion, social norms, and social capital on interpersonal violence.
    - The effect of psychological, social, and environmental factors not directly related to mental health on suicide.
    - The risks and benefits of firearm access or carrying.
2. *Improve understanding of the relationships between different types of violence. of particular concern are:*
    - The relationship between intimate partner violence victimization and perpetration to child abuse.
    - The effects of exposure to child abuse and intimate partner violence on suicidal behavior.
    - The effects of witnessing violence as a child in the home and community on violent behavior during adolescence and adulthood.
3. *Design and test preventive interventions for intimate partner violence, sexual violence, suicidal behavior, and child abuse.*
4. *Evaluate the feasibility and impact of screening and intervention methods in the acute medical care setting for youth interpersonal violence, child abuse, suicidal ideation, and intimate partner violence.*
5. *Advance our understanding of the effectiveness of interventions to prevent youth violence by evaluating:*
    - The long-term impact of promising interventions.
    - Multifaceted interventions to prevent youth violence.
    - The effect youth-violence-prevention strategies in diverse cultural and social settings.

- The cost effectiveness of promising interventions

_____
2015

FOA# CE15-001 Research Grants for Preventing Violence and Violence-Related Injury

NCIPC is soliciting investigator-initiated research that will help expand and advance knowledge in three areas: (1) how best to disseminate, implement, and translate evidence-based primary prevention strategies, programs and policies designed to reduce youth violence; (2) what works to prevent violence by rigorously evaluating primary prevention strategies, programs, and policies; and (3) research to determine ways to effectively prevent serious and lethal interpersonal and self-directed violence. The following research objectives are the focus of this announcement:

1. *Research to prevent youth violence:*
   - Dissemination/implementation/translation research to accelerate the adoption of evidence-based strategies, programs, and policies to prevent youth violence. There is particular interest in research that examines how models that have shown preventive effects on violence outcomes at the community level (e.g., Communities That Care, Cardiff Violence Prevention Program) can be adopted for use in high risk communities. Prevention models that bring together different sectors within communities to make data driven decisions about the set of evidence-based prevention activities that are most appropriate for the local community and then ensure implementation of those strategies have the potential to reduce risk for violence at the community level. Additional research is needed to help communities understand the capacity needed to implement these models, how the models can be appropriately adopted, and the effects of modifications on violence outcomes.
   - Effectiveness research to determine which community-level and societal-level strategies, programs, and policies effectively prevent youth violence. This includes studies to assess the effectiveness of economic development schemes (e.g., business improvement districts) and other efforts to improve the physical, social, and economic characteristics of neighborhoods; and the effectiveness of strategies aimed at reducing the level and concentration of community risk factors. There is also interest in the area of youth violence to assess the economic efficiency of strategies, programs and policies designed to prevent youth violence.
   - Effectiveness research to prevent serious and lethal violence among youth. Although there is a strong and growing evidence-base to prevent youth violence (e.g., universal school-based programs, parent/family focused interventions), there is less evidence addressing the more serious forms of violence among youth. Research is needed to determine ways to effectively prevent serious and lethal violence involving youth, particularly identifying and evaluating strategies addressing the leading mechanisms of youth homicide and assault-related injuries.
2. *Research to prevent teen dating violence, intimate partner violence, and sexual violence:*
   - Within the context of teen dating violence, intimate partner and sexual violence, there is interest in assessing the efficacy/effectiveness of primary prevention strategies aimed at preventing the initial perpetration of violence and promoting respectful, nonviolent relationships.6 Intervening in ways that prevent the initial perpetration of violence, that alter developmental trajectories leading to initial perpetration of violence, and that

promote an environment of nonviolence and respect is key to eliminating sexual and intimate partner violence.

- Effectiveness research to determine which community-level and societal-level strategies, programs, and policies effectively prevent teen dating violence, intimate partner and sexual
  violence. This includes studies to assess the effectiveness of economic schemes (e.g., microfinance, business improvement districts) and other efforts to improve the physical, social,
  and economic characteristics of neighborhoods and other settings; studies to assess the effectiveness of social and cultural norm change strategies at the community and societal level aimed at changing social contexts that condone or tolerate aggression and perpetration; and the effectiveness of strategies aimed at reducing the level and concentration of community risk factors.
- There is also interest in studies to assess the effectiveness of programs, policies, or strategies to prevent injuries and deaths in the context of teen dating violence and intimate partner violence. Women are much more likely than men to be injured or killed in incidents of violence between intimate partners. Research is needed to determine ways to effectively prevent serious and lethal violence against intimate partners, particularly identifying and evaluating strategies addressing the leading mechanisms of intimate partner homicide.

3. *Research to prevent suicidal behavior:*

- In the area of suicidal behavior, there is interest in efficacy/effectiveness studies of social, economic, and environmental primary prevention strategies to prevent suicidal behavior, including strategies aimed at enhancing connectedness for groups at high-risk for suicidal behavior and community-level efforts to reduce social isolation and stigma associated with seeking help for personal crises. There is also interest in studies to determine whether evidence-based programs for other forms of violence can also prevent suicidal behavior. Suicidal behavior and interpersonal violence share a number of risk and protective factors. However, only a limited number of evaluations of strategies that have demonstrated reductions in interpersonal violence have examined the impact of these strategies on suicidal behavior.
- There is also interest in studies assessing the effectiveness of programs, policies, and other intervention strategies to reduce access to lethal means. Research indicates that the means used in suicidal behavior (e.g., jumping from a bridge, hanging or suffocation versus taking pills) has a substantial impact on whether the act results in significant injury or death. Strategies related to means restriction, however, have rarely been rigorously evaluated particularly for their impact and feasibility for broader implementation. Knowledge is also limited regarding the effects of means restriction on different age groups, and how means substitution (i.e., switching from one suicide method to another) will limit the effectiveness of means-restriction strategies.

Grants for Injury Control Research Centers (ICRCs)

The purposes of this program are: 1) To support injury prevention and control research on priority issues as delineated in: Healthy People 2000; Injury Control in the 1990's: A National Plan for Action; Injury in America; Injury Prevention: Meeting the Challenge; and Cost of

Injury: A Report to the Congress; 2) To support ICRCs which represent CDC's largest national extramural investment in injury control research and training, intervention development, and evaluation; 3) To integrate collectively, in the context of a national program, the disciplines of engineering, epidemiology, medicine, biostatistics, public health, law and criminal justice, and behavioral and social sciences in order to prevent and control injuries more effectively; 4) To identify and evaluate current and new interventions for the prevention and control of injuries; 5) To bring the knowledge and expertise of ICRCs to bear on the development and improvement of effective public and private sector programs for injury prevention and control; and
6) To facilitate injury control efforts supported by various governmental agencies within a geographic region.

Grants for Academic Centers of Excellence for Youth Violence Prevention

The primary objectives of the Centers were to: 1) Build the scientific infrastructure necessary to support the development and widespread application of effective youth violence interventions, 2) promote interdisciplinary research strategies to address the problem of youth violence 3) foster collaboration between academic researchers and communities, and 4) empower communities to address the problem of youth violence. For the research component, centers could propose studies addressing the risk and protectives associated with youth violence as well as efficacy and effectiveness trials to prevent youth violence.

From: Frieden, Thomas (Tom) (CDC/OD)
Sent: Friday, April 15, 2016 4:37 PM
To: Payne, Rebecca L. (CDC/OD/OCS) <rco0@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>
Subject: Re: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

I don't have the annexes and question six implies recent funding in this area, is this the intent?

On Apr 15, 2016, at 4:22 PM, Payne, Rebecca L. (CDC/OD/OCS) <rco0@cdc.gov> wrote:

Apologies for the quick turn around – (b)(5)

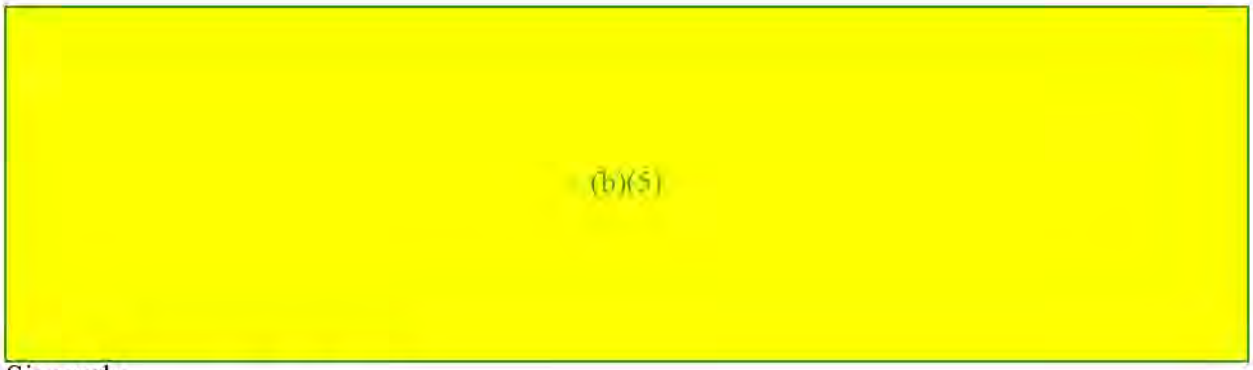
(b)(5)

BLUF: Senator Thomas Carper, Ranking Member of Homeland Security and Government Affairs, has written to the CDC Director to inquire about CDC's support for scientific research into the causes and prevention of gun violence gun violence.

DRAFT

[DATE]

The Honorable Thomas R. Carper
Ranking Member, Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510
Dear Senator Carper:



Sincerely,
Thomas R. Frieden, MD, MPH
Director, CDC
Enclosure

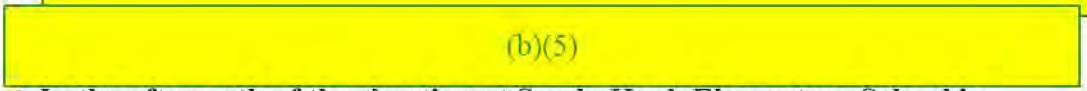
Centers for Disease Control and Prevention (CDC) Response to the Senate Committee on Homeland Security and Governmental Affairs regarding Gun Violence Research

1. **Please describe the CDC's policy toward scientific research into the causes and prevention of gun violence.**



2. **Has the CDC or the Department of Health and Human Services' (HHS) Office of the General Counsel conducted any analysis of the Dickey Amendment, including the types of gun violence research that are still permissible? If so, please provide this analysis.**



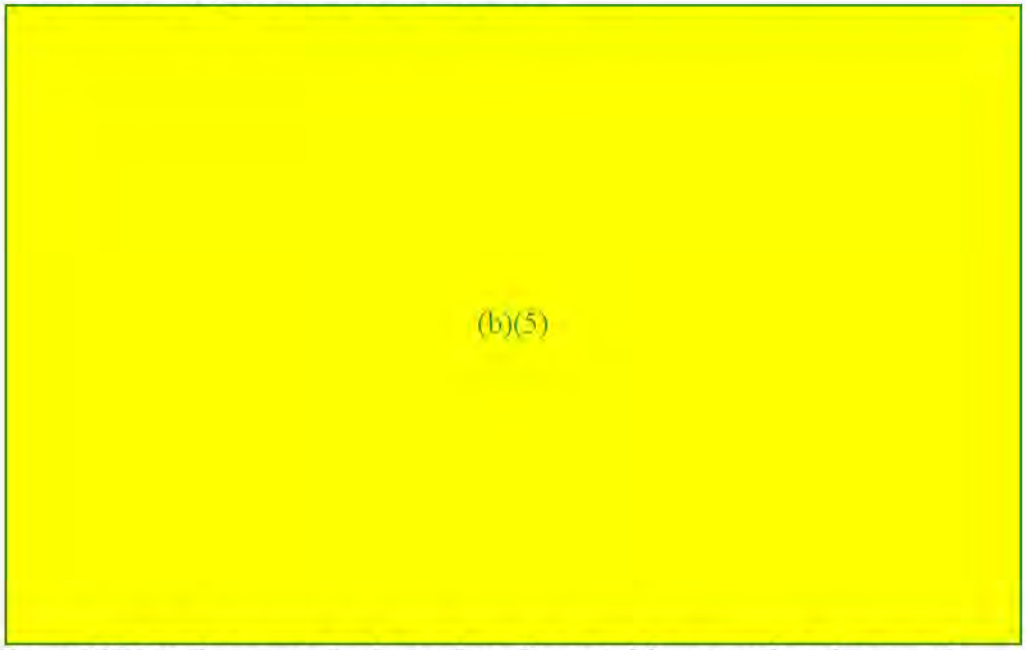


3. **In the aftermath of the shooting at Sandy Hook Elementary School in December 2012, President Obama issued a memorandum directing the Secretary of Health and Human Services (HHS), through the Director of the CDC and other agencies within HHS, to conduct or sponsor research**

into the causes of gun violence and the ways to prevent it. Please describe the efforts CDC has taken in response to this memorandum.

(b)(5)

4. **In April 2013, the National Center for Injury Prevention and Control asked the Institute of Medicine to recommend a research agenda on the public health aspects of firearm-related violence. Please describe the actions the CDC plans to take in response to the findings of the Institute of Medicine report issued in June 2013.**



5. **From 1996 to the present, please describe notable examples of research conducted or funded by the CDC, including research by or through the National Center for Injury Prevention and Control, related to understanding gun violence.**

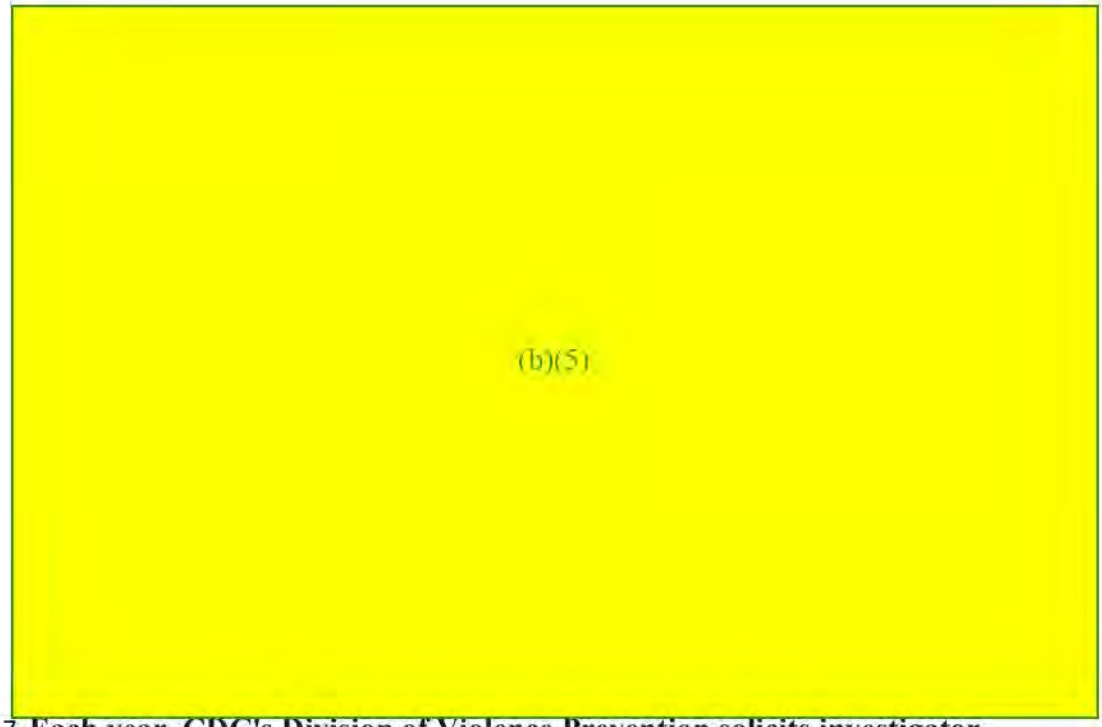


(b)(5)

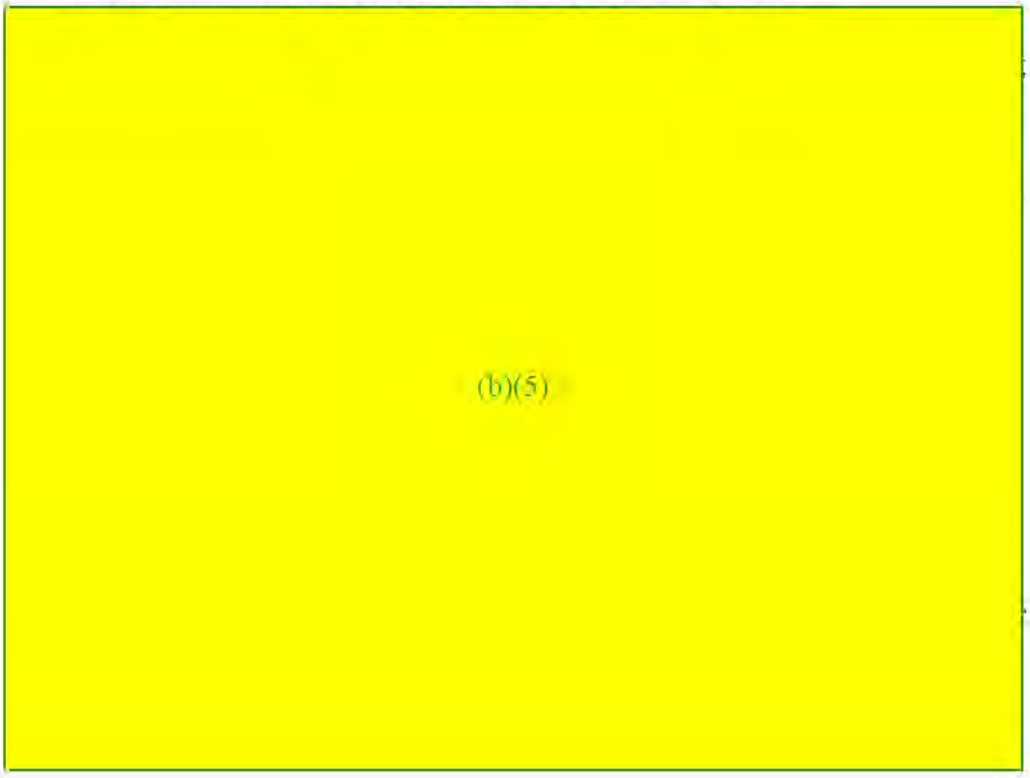
5a. Please also provide all instances when the CDC included requests for gun violence research in its research proposal solicitation materials.



6. **For each year from FY1996 to FY2015, what portion of the CDC's budget, including the budget of the National Center for Injury Prevention and Control, has been devoted to gun violence research?**



7. **Each year, CDC's Division of Violence Prevention solicits investigator-initiated research via an "RO1" Grant Program Announcement. The language in these announcements signals to grant-seeking public health researchers the research priorities of the CDC and its Division of Violence Prevention. Please describe any Division of Violence Prevention's RO1 Grant Program Announcements related to gun violence research put forward from 1996 to the present.**



(b)(5)

8. **The National Violent Death Reporting System collects and combines data from multiple sources to provide states and communities with a more complete record of the circumstances surrounding violent deaths. Participation from all 50 states would significantly increase the amount of data available to the National Violent Death Reporting System and, thereby, improve its effectiveness. In how many states has the National Violent Death Reporting System been implemented?**

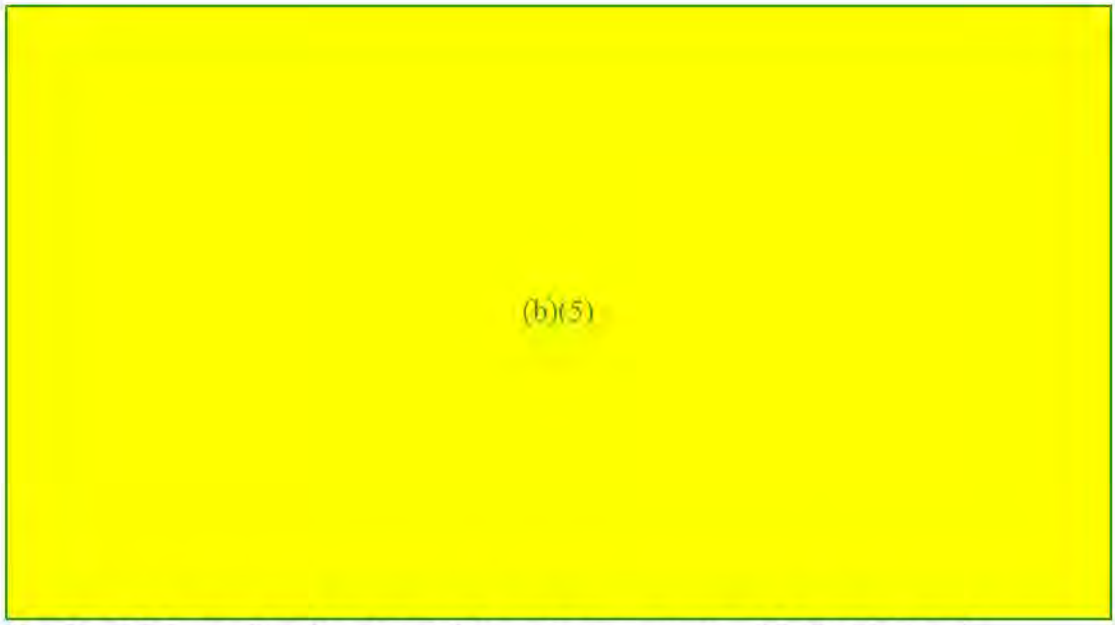
(b)(5)

8a. How many states have applied to be included in this system?

(b)(5)

8b. What circumstances have prevented all state applicants from being added to the National Violent Death Reporting System?

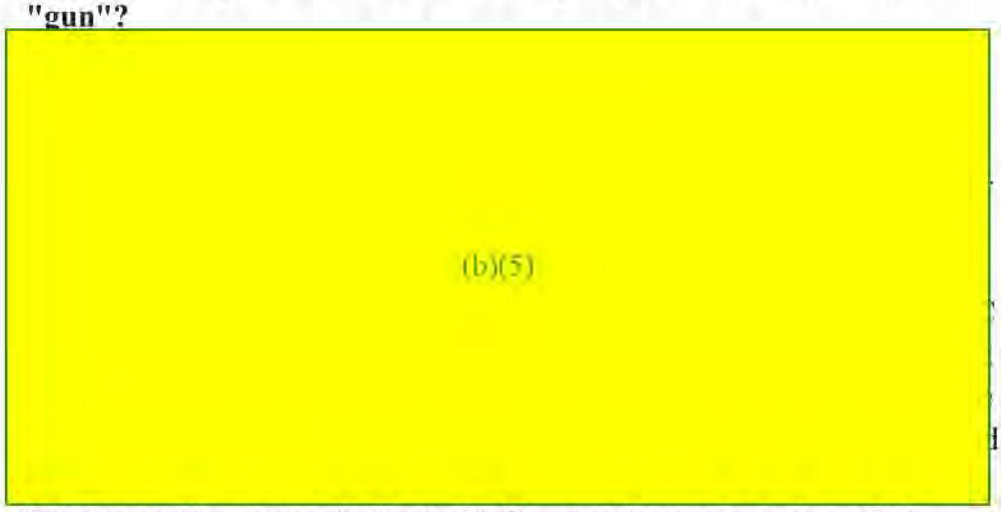
(b)(5)



9. **Has the CDC previously entered into any agreements with the National Rifle Association offering to provide advanced notice of any publication on the subject of gun violence? If so, please provide a description of any such agreements as well as communications and documents memorializing the agreements.**



10. **From 1996 to the present, has the CDC instructed any employee or researcher to not conduct scientific research on gun violence? Has the CDC instructed any employees or researchers to re-write reports submitted for publication to avoid using any variation of the word "gun"?**



11. **What remedies are available to CDC researchers who believe their scientific research has been inappropriately suppressed or discouraged?**

Please describe any review or appeals processes and include a list of the offices or review boards who would address any such concerns.

(b)(5)

Contessa Dean
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<2353690 Carper Response- Gun Violence Draft v5 (003).docx>

From: NCIPC Self-Directed Violence Prevention Listserv on behalf of Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: 17 Jun 2016 12:36:19 +0000
To: NCIPC-SDVP@LISTSERV.CDC.GOV
Subject: FW: [ICEHS Section] Re: fyi article on guns and cdc
Attachments: FA&suic&hom_Kates.pdf

Greetings:
In case you hadn't seen this article.
Alex C

From: ICEHS_Section@connect.apha.org [mailto:ICEHS_Section@connect.apha.org] **On Behalf Of** Dr. Donald Wayne Olson
Sent: Thursday, June 16, 2016 9:28 PM
To: Leslie Fisher ; ICEHS Section
Subject: [ICEHS Section] Re: fyi article on guns and cdc

Greetings Les
I've attached an article that expressly studied the question: WOULD BANNING FIREARMS REDUCE MURDER AND SUICIDE?
Their concluding remarks:

> If you are surprised by [our] finding[s], so [are we]. [We] did not begin this research with any intent to "exonerate" handguns, but there it is--a negative finding, to be sure, but a negative finding is nevertheless a positive contribution. It directs us where not to aim public health resources.[150]

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There's still a lot we don't know.(Shutterstock)

There are a few big things we know about gun violence in America: The US has way more guns per capita than any other country. It has far more gun homicides per capita than other wealthy countries. States with more guns have more gun deaths. And people with guns in their homes are more likely to be killed or to kill themselves with guns.

But just as importantly, there's an enormous amount that researchers still *don't* know. There's frustratingly little evidence on what policies work best to reduce gun violence. (Australia saw a drop in homicides and suicides **after confiscating everyone's guns in the 1990s**, but that would likely never happen here.) Experts still don't have a great sense of what impact stricter background checks have, or how the "informal" gun trade operates, or even how people use guns in crimes.

"We have superficial knowledge of most gun violence topics," says Michael Nance, director of the Pediatric Trauma Center at the Children's Hospital of Philadelphia. And this ignorance has major consequences. It's awfully hard to stop gun violence if we can't even agree on basic facts about how and why it happens.

This ignorance is partly by design. Since the 1990s,

Congress **has prevented various federal agencies** from gathering more detailed data on gun violence. The Centers for Disease Control and Prevention (CDC), which has elaborate data gathering and monitoring programs for other public health crises like Ebola or heart disease, has been dissuaded from researching gun violence. The Bureau of Alcohol, Tobacco, Firearms, and Explosives **can't distribute** much of its trace data for research purposes. Obamacare**limits** doctors' ability to gather data on patients' gun use.

To get a sense of what we're missing, I surveyed a number of researchers in the field and asked them about the most pressing questions about gun violence that they'd like to see answered. Here's what they said.

We still don't know some very

basic facts about gun violence in America



(Joshua Lott/Getty Images)

1) How are guns actually used? Tom Smith of NORC at the University of Chicago pointed out that "studying how guns are actually used in general" was a top research priority -- including the question of how many people use guns for defensive purposes.

Other researchers pointed to related questions like: What percentage of gun owners even commit gun crimes? Why do gun accidents occur? Who's involved? Are criminals deterred by guns? These questions are a very basic starting point.

2) Can we get better data on the victims of gun violence? Nance also pointed out that our data on the victims of gun violence leaves a lot to be desired. Researchers typically rely on death data ("one of the few known

and reliable data points -- you can't hide the bodies," he says). But without more detailed data on who actually owns guns and who is exposed to guns, it can be hard to put these deaths in context.

And it would be good to have more detailed data on gun injuries that *don't* result in death. Daniel Webster, a professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health, says, "We still don't know nearly enough about nonfatal gunshot wounds, including how often they occur." That makes it much harder to get a full picture of gun violence.

3) What state laws, if any, work best to reduce gun violence? Michael Siegel, a professor of public health at Boston University, pointed to these three (broad) topics as the most pressing unanswered questions:

1. What state laws, if any, are effective in reducing rates of firearm violence?

2. Is there a differential impact of state firearm-related laws on homicide rates among white vs. African-American persons?

3. Are higher gun ownership levels related to higher firearm homicide rates because of a causal relationship or because people respond to high homicide rates by purchasing firearms?

There has already been some research on state-level gun control policies. For example, after Connecticut passed a law requiring gun purchasers to first obtain a license, one study found that **gun homicides fell by 40 percent**. When Missouri repealed a similar law, **gun homicides increased by 23 percent**. But, in part

because they are retrospective and it's impossible to run controlled experiments, studies like these remain hotly debated.

And there are all sorts of related questions here that (other) researchers would love to know the answers to. Do limits on high-capacity magazines reduce deaths? Do restrictions on alcohol sales make any difference? What about policies that make concealed carry licenses easier to obtain?

To really dig in, researchers would have to study state policies in far more detail. But, says Siegel, that will require need much better data than is currently on offer. He'd like to see more detailed state-level data on household gun ownership, on firearm policies, and on how well (or not) those policies are actually enforced.

4) How do people who commit gun crimes

actually get access to their guns? Cathy Barber, who directs the Means Matter Campaign at the Harvard School of Public Health's Injury Control Research Center, listed these as big unanswered questions:

> Pretty much every gun starts out as a legal gun. Among the guns that are actually used in crimes, how did they get there?
>
> That is, how many are used by their initial legal purchaser and did that person pass a background check? If the gun was not used by the initial purchaser, how did it get to the person who used it in a crime? Straw purchase? Gun trafficking (buying in a state with lax laws and transporting for street sales in state with stricter laws)? Theft? (and what type of theft? Theft from individual homes or from gun shops or

what? And if from people's homes, do these tend to be unsecured guns kept for self-defense purchases - the gun in the bedside table?), etc., etc.

I think that both gun rights people and gun control people would be interested in the very specific answers to these questions and figuring out ways that we all could prevent the sort of cross-overs from legal to illegal possession and use.

A couple of other researchers agreed with this line of inquiry. Here's Nance: "We need to know how weapons move in society to know how to best limit movement in the wrong direction (to those unfit to own)." And here's Smith: "Understanding the 'informal' gun market, that is guns that are acquired from others than licenses firearms dealers and therefore without background checks."

5) Is there any way to predict gun suicides? Nearly 21,000 people in the United States use guns to kill themselves each year, accounting for about two-thirds of all gun deaths. "We need to know more about how to predict who will commit suicide using a firearm," says Webster, "and ways to prevent [it]."

Back in 2013, a report from the Institutes of Medicine **added some related questions**around this topic that needed answering: Does gun ownership affect whether people kill themselves? And what's the best way to restrict firearm access to those with severe mental illnesses?

6) Does media violence have any impact on actual violence? This question came from Brad Bushman, a professor of communication and psychology at Ohio State University:

My research focuses on media violence. We know that youth who see movie characters drink alcohol are more likely to drink alcohol themselves. Similarly, we know that youth who see movie characters smoke cigarettes are more likely to smoke themselves. What about the impact of youth seeing movie characters with guns? Does exposure to movie characters with guns influence youth attitudes and behaviors about guns (e.g., do they think guns are cooler? are they more willing to own or use a gun? do they think guns make males more masculine?)?

7) What do we know about stopping mass shootings? I'll add one more question to the list, which was considered a pressing research topic in the 2013 Institutes of

Medicine report: "What characteristics differentiate mass shootings that were prevented from those that were carried out?"

One big reason current research into US gun violence is so dismal



(Kevin Cox/Getty Images)

It's fair to call gun violence a public health crisis: Some 32,383 Americans were killed by guns in

2013. And for other health crises, like Ebola or heart disease, the CDC usually springs into action, by funding studies and research that look into the best policies to deal with the problem.

But that's not really the case here. Back in 1996, Congress worked with the National Rifle Association **to enact a law** banning the CDC from funding any research that would "advocate or promote gun control." Technically, this wasn't a ban on all gun research (and the CDC wasn't doing advocacy anyway). But the law seemed vague and menacing enough that the agency shied away from most gun violence research, period.

Funding for gun violence research by the CDC dropped 96 percent between 1996 and 2012. Today, federal agencies spend just $2 million annually on gun violence prevention -- compared with, say, $21 million **for**

the study of headaches. And the broader field has withered over that period: Gun studies as a percentage of peer-reviewed research dropped 60 percent since 1996. Today there are only about a dozen researchers in the country whose primary focus is on preventing gun violence.

Private foundations and universities, such as the Johns Hopkins Bloomberg School of Public Health, have been partly able to pick up the slack, but private funders can rarely sustain the big, complicated data gathering and monitoring programs that the federal government can conduct. And that's a problem because, as the researchers above noted, one of the biggest lacunae in gun research is data.

"If you look at other major public health issues, like Zika or Ebola or heart disease, the CDC is really a very authoritative source," says Andrew

Rosenberg of the Union of Concerned Scientists. "Privately funded research can be helpful, but there's no substitute for the CDC. They can do monitoring programs, long-term tracking, the stuff that's hard to fund with a one-off grant from this or that foundation."

Siegel agrees: "The CDC has a critical role to play, so the first matter that needs to be resolved is restoring the CDC's ability to conduct firearm-related research."

So will this situation ever change? After the Sandy Hook massacre in 2013, President Obama **signed an executive order** directing the CDC to start studying "the causes of gun violence." But very little has happened in the years since. The CDC didn't actually budget. The problem, Rosenberg says, is that so long as that congressional amendment is in place, the CDC is unlikely to move forward.

Lately, there have been some calls to restore research. Republican Rep. Jay Dickey, who spearheaded the original CDC amendment, **expressed remorse** about the whole thing last year: "I wish we had started the proper research and kept it going all this time. I have regrets. ... If we had somehow gotten the research going, we could have somehow found a solution to the gun violence without there being any restrictions on the Second Amendment."

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WOULD BANNING FIREARMS REDUCE MURDER AND SUICIDE?

A REVIEW OF INTERNATIONAL AND SOME DOMESTIC EVIDENCE

DON B. KATES* AND GARY MAUSER**

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INTRODUCTION

International evidence and comparisons have long been offered as proof of the mantra that more guns mean more deaths and that fewer guns, therefore, mean fewer deaths.[1] Unfortunately, such discussions are all too often been afflicted by misconceptions and factual error and focus on comparisons that are unrepresentative. It may be useful to begin with a few examples. There is a compound assertion that (a) guns are uniquely available in the United States compared with other modern developed nations, which is why (b) the United States has by far the highest murder rate. Though these assertions have been endlessly repeated, statement (b) is, in fact, false and statement (a) is substantially so.

Since at least 1965, the false assertion that the United States has the industrialized world's highest murder rate has been an artifact of politically motivated Soviet minimization designed to hide the true homicide rates.[2] Since well before that date, the Soviet Union

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1. *See, e.g.*, JOHN GODWIN, MURDER USA: THE WAYS WE KILL EACH OTHER 281 (1978) ("Areas with the highest proportion of gun owners also boast the highest homicide ratios; those with the fewest gun owners have the lowest."); N. PETE SHIELDS, GUNS DON'T DIE, PEOPLE DO 64 (1981) (quoting and endorsing an English academic's remark: "We cannot help but believe that America ought to share the basic premise of our gun legislation—that the availability of firearms breeds violence."); Janice Somerville, *Gun Control as Immunization*, AM. MED. NEWS, Jan. 3, 1994, at 9 (quoting public health activist Katherine Christoffel, M.D.: "Guns are a virus that must be eradicated . . . . Get rid of the guns, get rid of the bullets, and you get rid of the deaths."); Deane Calhoun, *From Controversy to Prevention: Building Effective Firearm Policies*, INJ. PROTECTION NETWORK NEWSL., Winter 1989–90, at 17 ("[G]uns are not just an inanimate object [sic], but in fact are a social ill."); *see also* WENDY CUKIER & VICTOR W. SIDEL, THE GLOBAL GUN EPIDEMIC: FROM SATURDAY NIGHT SPECIALS TO AK-47S (2006); Susan Baker, *Without Guns, Do People Kill People?* 75 AM. J. PUB. HEALTH 587 (1985); Paul Cotton, *Gun-Associated Violence Increasingly Viewed as Public Health Challenge*, 267 J. AM. MED. ASS'N 1171 (1992); Diane Schetky, *Children and Handguns: A Public Health Concern*, 139 AM. J. DIS. CHILD. 229, 230 (1985); Lois A. Fingerhut & Joel C. Kleinman, *International and Interstate Comparisons of Homicides Among Young Males*, 263 J. AM. MED. ASS'N 3292, 3295 (1990).

2. *See* William Alex Pridemore, *Using Newly Available Homicide Data to Debunk Two Myths About Violence in an International Context: A Research Note*, 5 HOMICIDE STUD. 267 (2001).

possessed extremely stringent gun controls[3] that were effectuated by a police state apparatus providing stringent enforcement.[4] So successful was that regime that few Russian civilians now have firearms and very few murders involve them.[5] Yet, manifest success in keeping its people disarmed did not prevent the Soviet Union from having far and away the highest murder rate in the developed world.[6] In the 1960s and early 1970s, the gun-less Soviet Union's murder rates paralleled or generally exceeded those of gun-ridden America. While American rates stabilized and then steeply declined, however, Russian murder increased so drastically that by the early 1990s the Russian rate was three times higher than that of the United States. Between 1998-2004 (the latest figure available for Russia), Russian murder rates were nearly four times higher than American rates. Similar murder rates also characterize the Ukraine, Estonia, Latvia, Lithuania, and various other now-independent European nations of the former U.S.S.R.[7] Thus, in the United States and the former Soviet Union transitioning into current-day Russia, "homicide results suggest that where

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3. *See* GEORGE NEWTON & FRANKLIN ZIMRING, FIREARMS AND VIOLENCE IN AMERICAN LIFE: A STAFF REPORT SUBMITTED TO THE NATIONAL COMMISSION ON THE CAUSES AND PREVENTION OF VIOLENCE 119 & n.3 (1970).

4. Russian law flatly prohibits civilian possession of handguns and limits long guns to licensed hunters. *Id.* For more on the stringency of enforcement, see Raymond Kessler, *Gun Control and Political Power*, 5 LAW & POL'Y Q. 381, 389 (1983), and Randy E. Barnett & Don B. Kates, *Under Fire: The New Consensus on the Second Amendment*, 45 EMORY L. J. 1139, 1239 (1996) (noting an unusual further element of Soviet gun policy: the Soviet Army adopted unique firearm calibers so that, even if its soldiers could not be prevented from returning with foreign gun souvenirs from foreign wars, ammunition for them would be unavailable in the Soviet Union).

5. *See* Pridemore, *supra* note 2, at 271.

6. Russian homicide data given in this article (for years 1965–99) were kindly supplied us by Professor Pridemore from his research in Russian ministry sources (on file with authors). *See also infra* Table 1 (reporting Russian homicide data for 2002).

7. The highest U.S. homicide rate ever reported was 10.5 per 100,000 in 1980. *See* Jeffery A. Miron, *Violence, Guns, and Drugs: A Cross-Country Analysis*, 44 J.L. & ECON. 615, 624–25 tbl.1 (2001). As of 2001, the rate was below 6. *Id.* The latest rates available for the Ukraine, Belarus, and other former Soviet nations in Europe come from the mid-1990s, when all were well above 10 and most were 50% to 150% higher. *Id.*

Note that the U.S. rates given above are rates reported by the FBI. There are two different sources of U.S. murder rates. The FBI murder data is based on reports it obtains from police agencies throughout the nation. These data are significantly less complete than the alternative (used in this article unless otherwise explicitly stated) rates of the U.S. Public Health Service, which are derived from data collected from medical examiners' offices nationwide. Though the latter data are more comprehensive, and the Public Health Service murder rate is slightly higher, they have the disadvantage of being slower to appear than the FBI homicide data.

guns are scarce other weapons are substituted in killings."[8] While American gun ownership is quite high, Table 1 shows many other developed nations (e.g., Norway, Finland, Germany, France, Denmark) with high rates of gun ownership. These countries, however, have murder rates as low or lower than many developed nations in which gun ownership is much rarer. For example, Luxembourg, where handguns are totally banned and ownership of any kind of gun is minimal, had a murder rate nine times higher than Germany in 2002.[9]

Table 1: European Gun Ownership and Murder Rates
(rates given are per 100,000 people and in descending order)

Nation	Murder Rate	Rate of Gun Ownership
Russia	20.54 [2002]	4,000
Luxembourg	9.01 [2002]	c. 0
Hungary	2.22 [2003]	2,000
Finland	1.98 [2004]	39,000
Sweden	1.87 [2001]	24,000
Poland	1.79 [2003]	1,500
France	1.65 [2003]	30,000
Denmark	1.21 [2003]	19,000
Greece	1.12 [2003]	11,000
Switzerland	0.99 [2003]	16,000
Germany	0.93 [2003]	30,000
Norway	0.81 [2001]	36,000
Austria	0.80 [2002]	17,000

Notes: This table covers all the Continental European nations for which the two data sets given are both available. In every case, we have given the homicide data for 2003 or the closest year thereto because that is the year of the publication from which the gun ownership data are taken. Gun ownership data comes from GRADUATE INSTITUTE OF INTERNATIONAL STUDIES, SMALL ARMS SURVEY 64 tbl.2.2, 65 tbl.2.3 (2003).

The homicide rate data comes from an annually published report, CANADIAN CENTRE FOR JUSTICE STATISTICS, HOMICIDE IN CANADA, JURISTAT, for the years 2001–2004. Each year's report gives homicide statistics for a dozen or so foreign nations in a section labeled "Homicide Rates for Selected Countries." This section of the reports gives no explana-

8. GARY KLECK, TARGETING GUNS: FIREARMS AND THEIR CONTROL 20 (1997) (discussing patterns revealed by studies in the United States).

9. Our assertions as to the legality of handguns are based on COMM'N ON CRIME PREVENTION & CRIM. JUSTICE, U.N. ECON. & SOC. COUNCIL, UNITED NATIONS INTERNATIONAL STUDY ON FIREARMS REGULATION 26, tbl. 2-1 (1997 draft).

> tion of why it selects the various nations whose homicide statistics it covers. Also without explanation, the nations covered differ from year to year. Thus, for instance, murder statistics for Germany and Hungary are given in all four of the pamphlets (2001, 2002, 2003, 2004), for Russia in three years (2001, 2002, and 2004), for France in two years (2001 and 2003), and for Norway and Sweden in only one year (2001).

The same pattern appears when comparisons of violence to gun ownership are made within nations. Indeed, "data on firearms ownership by constabulary area in England," like data from the United States, show "a *negative* correlation,"[10] that is, "where firearms are most dense violent crime rates are lowest, and where guns are least dense violent crime rates are highest."[11] Many different data sets from various kinds of sources are summarized as follows by the leading text:

> [T]here is no consistent significant positive association between gun ownership levels and violence rates: across (1) time within the United States, (2) U.S. cities, (3) counties within Illinois, (4) country-sized areas like England, U.S. states, (5) regions of the United States, (6) nations, or (7) population subgroups . . . .[12]

A second misconception about the relationship between firearms and violence attributes Europe's generally low homicide

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10. JOYCE LEE MALCOLM, GUNS AND VIOLENCE: THE ENGLISH EXPERIENCE 204 (2002).

11. Hans Toch & Alan J. Lizotte, *Research and Policy: The Case for Gun Control, in* PSYCHOLOGY & SOCIAL POLICY 223, 232 (Peter Suedfeld & Philip E. Tetlock eds., 1992); *see also id.* at 234 & n.10 ("[T]he fact that national patterns show little violent crime where guns are most dense implies that guns do not elicit aggression in any meaningful way. . . . Quite the contrary, these findings suggest that high saturations of guns in places, or something correlated with that condition, inhibit illegal aggression.").

Approaching the matter from a different direction, the earliest data (nineteenth century on) reveals that the American jurisdictions with the most stringent gun controls are in general the ones with the highest murder rates. Conversely, American states with homicide rates as low as Western Europe's have high gun ownership, and impose no controls designed to deny guns to law-abiding, responsible adults. Many possible reasons may be offered for these two facts, but none suggests that gun control reduces murder.

For examination of a wide variety of studies finding little evidence in support of the efficacy of gun controls in reducing violence, see JAMES B. JACOBS, CAN GUN CONTROL WORK? 111–20 (2002); KLECK, *supra* note 8, at 351–77; JOHN R. LOTT, JR., MORE GUNS, LESS CRIME: UNDERSTANDING CRIME AND GUN CONTROL LAWS 19–20 (1998); JAMES D. WRIGHT ET AL., UNDER THE GUN: WEAPONS, CRIME AND VIOLENCE IN AMERICA 307–08 (1983); Matthew R. DeZee, *Gun Control Legislation: Impact and Ideology*, 5 LAW & POL'Y Q. 367, 369–71 (1983).

12. KLECK, *supra* note 8, at 22-23.

rates to stringent gun control. That attribution cannot be accurate since murder in Europe was at an all-time low *before* the gun controls were introduced.[13] For instance, virtually the only English gun control during the nineteenth and early twentieth centuries was the practice that police patrolled without guns. During this period gun control prevailed far less in England or Europe than in certain American states which nevertheless had—and continue to have—murder rates that were and are comparatively very high.[14]

In this connection, two recent studies are pertinent. In 2004, the U.S. National Academy of Sciences released its evaluation from a review of 253 journal articles, 99 books, 43 government publications, and some original empirical research. It failed to identify any gun control that had reduced violent crime, suicide, or gun accidents.[15] The same conclusion was reached in 2003 by the U.S. Centers for Disease Control's review of then-extant studies.[16]

Stringent gun controls were not adopted in England and Western Europe until after World War I. Consistent with the outcomes of the recent American studies just mentioned, these strict controls did not stem the general trend of ever-growing violent crime throughout the post-WWII industrialized world including the United States and Russia. Professor Malcolm's study of English gun law and violent crime summarizes that

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13. Barnett & Kates, *supra* note 4, at 138–42.

14. In the period between 1900 and 1935, Arkansas, Hawaii, Michigan, Missouri, New Jersey, New York, North Carolina, Oregon, and South Carolina adopted laws variously requiring a license to own or buy a handgun or banning handgun purchase altogether, and "Saturday Night Special"-type bans existed in Tennessee, Arkansas, and various other Southern states. Don B. Kates, Jr., *Toward a History of Handgun Prohibition in the United States*, *in* RESTRICTING HANDGUNS: THE LIBERAL SKEPTICS SPEAK OUT 7, 14–15 (Don B. Kates, Jr. ed., 1979).

15. CHARLES F. WELLFORD ET AL., NAT'L RESEARCH COUNCIL, FIREARMS AND VIOLENCE: A CRITICAL REVIEW 6–10 (2004). It is perhaps not amiss to note that the review panel, which was set up during the Clinton Administration, was composed almost entirely of scholars who, to the extent their views were publicly known before their appointments, favored gun control.

16. Task Force on Community Preventitive Servs., Ctrs. for Disease Control, *First Reports Evaluating the Effectiveness of Strategies for Preventing Violence: Firearms Laws*, 52 MORTALITY & MORBIDITY WKLY. REP. (RR-14 RECOMMENDATIONS & REP.) 11, 16 (2003), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5214a2.htm. The CDC is vehemently anti-gun and interpreted its results to show not that the "more guns equal more death" mantra is erroneous, but only that the scores of studies it reviewed were inconclusively done.

nation's nineteenth and twentieth century experience as follows:

> The peacefulness England used to enjoy was not the result of strict gun laws. When it had no firearms restrictions [nineteenth and early twentieth century] England had little violent crime, while the present extraordinarily stringent gun controls have not stopped the increase in violence or even the increase in armed violence.[17]
>
> Armed crime, never a problem in England, has now become one. Handguns are banned but the Kingdom has millions of illegal firearms. Criminals have no trouble finding them and exhibit a new willingness to use them. In the decade after 1957, the use of guns in serious crime increased a hundredfold.[18]

In the late 1990s, England moved from stringent controls to a complete ban of all handguns and many types of long guns. Hundreds of thousands of guns were confiscated from those owners law-abiding enough to turn them in to authorities. Without suggesting this caused violence, the ban's ineffectiveness was such that by the year 2000 violent crime had so increased that England and Wales had Europe's highest violent crime rate, far surpassing even the United States.[19] Today, English news media headline violence in terms redolent of the doleful, melodramatic language that for so long characterized American news reports.[20] One aspect of England's recent ex-

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17. MALCOLM, *supra* note 10, at 219.

18. *Id.* at 209.

19. *See* Esther Bouten et al., *Criminal Victimization in Seventeen Industrialized Countries*, *in* CRIME VICTIMIZATION IN COMPARATIVE PERSPECTIVE: RESULTS FROM THE INTERNATIONAL CRIME VICTIMS SURVEY, 1989–2000 at 13, 15–16 (Paul Nieuwbeerta ed., 2002). The surveys involved were conducted under the auspices of the governments of each nation and the general supervision of the University of Leiden and the Dutch Ministry of Justice.

20. *See, e.g.*, *Gun Crime Growing "Like Cancer,"* BBC NEWS, May 21, 2003, http://news.bbc.co.uk/1/hi/England/3043701.stm; David Bamber, *Gun Crime Trebles as Weapons and Drugs Flood British Cities*, TELEGRAPH ONLINE (London), Feb. 27, 2002, http://www.telegraoh.co.uk/news/main.jhtml?xml=/news/2002/02/24/nguns24.xml; Jason Bennetto, *Firearms Amnesty to Tackle Surge in Gun Crime*, INDEPENDENT (London), Dec. 27, 2002, at 1; Ian Burrell, *Police Move to Tackle Huge Rise in Gun Crime*, INDEPENDENT (London), Jan. 15, 2001, at 3; Daniel Foggo & Carl Fellstrom, *"We Are Reeling with the Murders, We Are in a Crisis with Major Crime,"* SUNDAY TELEGRAPH (London), Mar. 13, 2005, at 4; Johann Hari, *The British Become Trigger Happy*, NEW STATESMAN (London), Nov. 5, 2001, at 35; Philip Johnston, *Gun Crime Rises Despite Dunblane Pistol Ban*, DAILY TELEGRAPH (London), Jul. 17, 2001, at 05; David Leppard & Rachel Dobson, *Murder Rate Soars to Highest for a Century*, SUNDAY TIMES (Lon-

perience deserves note, given how often and favorably advocates have compared English gun policy to its American counterpart over the past 35 years.[21] A generally unstated issue in this notoriously emotional debate was the effect of the Warren Court and later restrictions on police powers on American gun policy. Critics of these decisions pointed to soaring American crime rates and argued simplistically that such decisions caused, or at least hampered, police in suppressing crime. But to some supporters of these judicial decisions, the example of England argued that the solution to crime was to restrict guns, not civil liberties. To gun control advocates, England, the cradle of our liberties, was a nation made so peaceful by strict gun control that its police did not even need to carry guns. The United States, it was argued, could attain such a desirable situation by radically reducing gun ownership, preferably by banning and confiscating handguns.

The results discussed earlier contradict those expectations. On the one hand, despite constant and substantially increasing gun ownership, the United States saw progressive and dramatic reductions in criminal violence in the 1990s. On the other hand, the same time period in the United Kingdom saw a constant and dramatic increase in violent crime to which England's response was ever-more drastic gun control including, eventually, banning and confiscating all handguns and many types of long guns.[22] Nevertheless, criminal violence rampantly increased so that by 2000 England surpassed the United States to become one of the developed world's most violence-ridden nations.

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don), Oct. 13, 2002, at 1; Adam Mitchell, *Gun Killings Double as Police Claim Progress*, DAILY TELEGRAPH (London), Aug. 17, 2001, at 13; John Steele, *Police Fear a New Crime Wave as School-Age Muggers Graduate to Guns*, DAILY TELEGRAPH (London), Jan. 3, 2002, at 04; Jon Ungoed-Thomas, *Killings Rise as 3m Illegal Guns Flood Britain*, SUNDAY TIMES (London), Jan. 16, 2000; Peter Woolrich, *Britain's Tough Gun Control Laws Termed Total Failure: Land of Hope and Gunrunning*, PUNCH MAG., May 3, 2000.

21. *See, e.g.*, CARL BAKAL, THE RIGHT TO BEAR ARMS 10–11, 31, 279 (1966); RAMSEY CLARK, CRIME IN AMERICA 104–05, 109 (1970); AMITAI ETZIONI & RICHARD REMP, TECHNOLOGICAL SHORTCUTS TO SOCIAL CHANGE 136 (1973); Natl Coalition to Ban Handguns, A Shooting Gallery Called America (undated, unpaginated pamphlet); SHIELDS, *supra* note 1, at 63–64; Irwin Bloch, *Gun Control Would Reduce Crime, reprinted in* Would Gun Control Reduce Crime 197 (David Bender ed., 1989); Robert S. Drinan, *Banning Handguns Would Reduce Crime, reprinted in* GUNS & CRIME 45–46 (Tarara Roleff ed., 1999).

22. MALCOLM, *supra* note 10, at 164–216. We should clarify that the twin trends toward more violent crime and more gun control began long before the 1990s. *See id.*

To conserve the resources of the inundated criminal justice system, English police no longer investigate burglary and "minor assaults."[23] As of 2006, if the police catch a mugger, robber, or burglar, or other "minor" criminal in the act, the policy is to release them with a warning rather than to arrest and prosecute them.[24] It used to be that English police vehemently opposed the idea of armed policing. Today, ever more police are being armed. Justifying the assignment of armed squads to block roads and carry out random car searches, a police commander asserts: "It is a massive deterrent to gunmen if they think that there are going to be armed police."[25] How far is that from the rationale on which 40 American states have enacted laws giving qualified, trained citizens the right to carry concealed guns? Indeed, news media editorials have appeared in England arguing that civilians should be allowed guns for defense.[26] There is currently a vigorous controversy over proposals (which the Blair government first endorsed but now opposes) to amend the law of self-defense to protect victims from prosecution for using deadly force against burglars.[27]

The divergence between the United States and the British Commonwealth became especially pronounced during the

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23. Daniel Foggo, *Don't Bother About Burglary, Police Told*, SUNDAY TELEGRAPH (LONDON), Jan. 12, 2003, at 1 ("Police have been ordered not to bother investigating crimes such as burglary, vandalism and assaults unless evidence pointing to the culprits is easily available, The Sunday Telegraph can reveal. Under new guidelines, officers have been informed that only "serious" crimes, such as murder, rape or so-called hate crimes, should be investigated as a matter of course. In all other cases, unless there is immediate and compelling evidence, such as fingerprints or DNA material, the crime will be listed for no further action.").

24. Steve Doughty, *Let Burglars Off With Caution Police Told*, DAILY MAIL (London), Apr. 3, 2006, at 4.

25. Matthew Beard, *Armed Police to Man Checkpoints in London as Drug-Related Crime Soars*, INDEPENDENT (London), Sept. 7, 2002, at 2.

26 *See* Simon Heffer, *If the State Fails Us, We Must Defend Ourselves*, TELEGRAPH ONLINE (London), Feb. 24, 2002, http://www.telegraph.co.uk/opinion/main.jhtml?xml=/opinion/2002/02/24/do2401.xml; *see also* Ian Bell, *Dublane Made Us All Think About Gun Control . . . So What Went Wrong?*, SUNDAY HERALD (Scotland), Feb. 24, 2007, http://www.sundayherald.com/oped/opinion/display.var.1217778.0.dunblane_made_us_all_think_about_gun_control_so_what_went_wrong.php; Comment, *The Night My Daughter Was Stabbed—And My Liberal Instincts Died*, DAILY MAIL (London), Mar. 5, 2007, http://www.dailymail.co.uk/pages/live/femail/article.html?in_ar-ticle_id=440318&in_page_id=1766&ito=1490.

27. *See* Melissa Kite, *Tories Launch Bill to Give Householders the Power to Tackle Intruders*, SUNDAY TELEGRAPH (London), Dec. 26, 2004, at 4; *see also* Renee Lerner, *The Worldwide Popular Revolt Against Proportionality in Self-Defense Law*, 2 J.L. ECON. & POL'Y (2007).

1980s and 1990s. During these two decades, while Britain and the Commonwealth were making lawful firearm ownership increasingly difficult, more than 25 states in the United States passed laws allowing responsible citizens to carry concealed handguns. There are now 40 states where qualified citizens can obtain such a handgun permit.[28] As a result, the number of U.S. citizens allowed to carry concealed handguns in shopping malls, on the street, and in their cars has grown to 3.5 million men and women.[29] Economists John Lott and David Mustard have suggested that these new laws contributed to the drop in homicide and violent crime rates. Based on 25 years of correlated statistics from all of the more than 3,000 American counties, Lott and Mustard conclude that adoption of these statutes has deterred criminals from confrontation crime and caused murder and violent crime to fall faster in states that adopted this policy than in states that did not.[30]

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28. In March 2006, Kansas and Nebraska became the 39th and 40th states, respectively, to pass "shall issue" concealed carry legislation. In Kansas, the state legislature voted to overturn the governor's veto of the bipartisan legislation. *Kansas House Overrides Concealed-Guns-Bill Veto*, DESERET MORNING NEWS, Mar. 24, 2006. In Nebraska, the governor signed the bill as passed by the state legislature. Kevin O'Hanlon, *Concealed-Weapons Bill Adopted*, LINCOLN JOURNAL STAR, Mar. 31, 2006.

29. Don Kates, *The Limited Importance of Gun Control from a Criminological Perspective, in* SUING THE GUN INDUSTRY: A BATTLE AT THE CROSSROADS OF GUN CONTROL AND MASS TORTS 62, 64 (Timothy D. Lytton ed., 2005).

30. *See* John R. Lott Jr. & David B. Mustard, *Crime, Deterrence, and Right-to-Carry Concealed Handguns*, 26 J. LEGAL STUD. 1, 1 (1997); *see also* JOHN R. LOTT, JR., MORE GUNS, LESS CRIME 19 (2d. ed. 2000). This conclusion is vehemently rejected by anti-gun advocates and academics who oppose armed self-defense. *See, e.g.*, Albert W. Alschuler, *Two Guns, Four Guns, Six Guns, More Guns: Does Arming the Public Reduce Crime?*, 31 VAL. U. L. REV. 365, 366 (1997); Ian Ayres & John J. Donohue III, *Shooting Down the 'More Guns, Less Crime' Hypothesis*, 55 STAN. L. REV. 1193, 1197 (2003); Dan A. Black & Daniel S. Nagin, *Do Right-to-Carry Laws Deter Violent Crime?*, 27 J. LEGAL STUD. 209, 209 (1998); Franklin Zimring & Gordon Hawkins, *Concealed Handguns: The Counterfeit Deterrent*, RESPONSIVE COMMUNITY, Spring 1997, at 46; Daniel W. Webster, *The Claims That Right-to-Carry Laws Reduce Violent Crime Are Unsubstantiated* (Johns Hopkins Center for Gun Policy and Research, 1997).

Several critics have now replicated Lott's work using additional or different data, additional control variables, or new or different statistical techniques they deem superior to those Lott used. Interestingly, the replications all confirm Lott's general conclusions; some even find that Lott *under*estimated the crime-reductive effects of allowing good citizens to carry concealed guns. *See* Jeffrey A. Miron, *Violence, Guns, and Drugs: A Cross-Country Analysis*, 44 J.L. & ECON. 615 (2001); David B. Mustard, *The Impact of Gun Laws on Police Deaths*, 44 J.L. & ECON. 635 (2001); John R. Lott, Jr. & John E. Whitley, *Safe-Storage Gun Laws: Accidental Deaths, Suicides, and Crime*, 44 J.L. & ECON. 659 (2001); Thomas B. Marvell, *The Impact of Banning Juvenile Gun Possession*, 44 J.L. & ECON. 691 (2001); Jeffrey S. Parker, *Guns, Crime, and Academics: Some Reflections on the Gun Control Debate*, 44 J.L. & ECON. 715 (2001); Bruce L. Benson &

As indicated in the preceding footnote, the notion that more guns reduce crime is highly controversial. What the controversy has obscured from view is the corrosive effect of the Lott and Mustard work on the tenet that more guns equal more murder. As previously stated, adoption of state laws permitting millions of qualified citizens to carry guns has not resulted in more murder or violent crime in these states. Rather, adoption of these statutes has been followed by very significant reductions in murder and violence in these states.

To determine whether this expansion of gun availability caused reductions in violent crime requires taking account of various other factors that might also have contributed to the decline. For instance, two of Lott's major critics, Donohue and Levitt, attribute much of the drop in violent crime that started in 1990s to the legalization of abortion in the 1970s, which they argue resulted in the non-birth of vast numbers of children who would have been disproportionately involved in violent crime had they existed in the 1990s.[31]

The Lott-Mustard studies did not address the Donohue-Levitt thesis. Lott and Mustard did account, however, for two peculiarly American phenomena which many people believed may have been responsible for the 1990s crime reduction: the dramatic increase of the United States prison population and the number of executions. The prison population in the United States tripled during this time period, jumping from approximately 100 prisoners per 100,000 in the late 1970s to more than 300 per 100,000 people in the general population in the early 1990s.[32] In addition, executions in the United States soared

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Brent D. Mast, *Privately Produced General Deterrence*, 44 J.L. & ECON. 725 (2001); David E. Olson & Michael D. Maltz, *Right-to-Carry Concealed Weapon Laws and Homicide in Large U.S. Counties: The Effect on Weapon Types, Victim Characteristics, and Victim-Offender Relationships*, 44 J.L. & ECON. 747 (2001); Florenz Plassmann & T. Nicolaus Tideman, *Does the Right to Carry Concealed Handguns Deter Countable Crimes? Only a Count Analysis Can Say*, 44 J.L. & ECON. 771 (2001); Carlisle E. Moody, *Testing for the Effects of Concealed Weapons Laws: Specification Errors and Robustness*, 44 J.L. & ECON. 799 (2001); *see also* Florenz Plassman & John Whitley, *Confirming 'More Guns, Less Crime,'* 55 STAN. L. REV. 1313, 1316 (2003). In 2003, Lott reiterated and extended his findings, which were subsequently endorsed by three Nobel laureates. *See* JOHN R. LOTT, JR., THE BIAS AGAINST GUNS (2003).

31. *See* John J. Donohue III & Steven D. Levitt, *The Impact of Legalized Abortion on Crime*, 116 Q. J. ECON. 379 (2001).

32. *See* Bureau of Justice Statistics, Key Facts at a Glance: Incarceration Rate, 1980–2004 (Oct. 23, 2005), http://www.ojp.usdoj.gov/bjs/glance/tables/incrttab.htm, citing ALLEN BECK & PAIGE HARRISON, BUREAU OF JUSTICE STATISTICS, CORRECTIONAL POPULATIONS IN THE UNITED STATES 1997 (2000), *available at*

from approximately 5 per year in the early 1980s to more than 27 per year in the early 1990s.[33] Neither of these trends is reflected in Commonwealth countries.

Although the reason is thus obscured, the undeniable result is that violent crime, and homicide in particular, has plummeted in the United States over the past 15 years.[34] The fall in the American crime rate is even more impressive when compared with the rest of the world. In 18 of the 25 countries surveyed by the British Home Office, violent crime increased during the 1990s.[35] This contrast should induce thoughtful people to wonder what happened in those nations, and to question policies based on the notion that introducing increasingly more restrictive firearm ownership laws reduces violent crime. Perhaps the United States is doing something right in promoting firearms for law-abiding responsible adults. Or perhaps the United States' success in lowering its violent crime rate relates to increasing its prison population or its death sentences.[36] Further research is required to identify more precisely which elements of the United States' approach are the most important, or whether all three elements acting in concert were necessary to reduce violent crimes.

I. VIOLENCE: THE DECISIVENESS OF SOCIAL FACTORS

One reason the extent of gun ownership in a society does not spur the murder rate is that murderers are not spread evenly throughout the population. Analysis of perpetrator studies shows that violent criminals—especially murderers—"*almost*

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http://www.ojp.usdoj.gov/bjs/pub/pdf/cpus97.pdf, and ALLEN BECK & PAIGE HARRISON, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2004 (2005), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/p04.pdf.).

33. THOMAS BONCZAR & TRACY L. SNELL, BUREAU OF JUSTICE STATISTICS BULLETIN, CAPITAL PUNISHMENT 2003, (2004), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/cp03.pdf.

34. *See generally* FBI, VIOLENT CRIME, http://www.fbi.gov/ucr/05cius/offenses/violent_crime/index.html; FBI, CRIME IN THE UNITED STATES BY VOLUME AND RATE PER 100,000 INHABITANTS, 1986–2005, http://www.fbi.gov/ucr/05cius/data/table_01.html.

35. *See* Gordon Barclay et al., *International Comparisons of Criminal Justice Statistics 1999*, HOME OFFICE STAT. BULL. (Research Development and Statistics, U.K. Home Office, London, U.K.), 2001, *available at* http://www.homeoffice.gov.uk/rds/pdfs/hosb601.pdf.

36. Several recent studies by economists calculate that each execution deters the commission of 19 murders. *See* Cass R. Sunstein & Adrian Vermuele, *Is Capital Punishment Morally Required? Acts, Omissions, and Life-Life Tradeoffs*, 58 STAN. L. REV. 703 (2005).

uniformly have a long history of involvement in criminal behavior."[37] So it would not appreciably raise violence if all law-abiding, responsible people had firearms because they are not the ones who rape, rob, or murder.[38] By the same token, violent crime would not fall if guns were totally banned to civilians. As the respective examples of Luxembourg and Russia suggest,[39] individuals who commit violent crimes will either find guns despite severe controls or will find other weapons to use.[40]

Startling as the foregoing may seem, it represents the cross-national norm, not some bizarre departure from it. If the mantra "more guns equal more death and fewer guns equal less death" were true, broad based cross-national comparisons should show that nations with higher gun ownership per capita consistently have more death. Nations with higher gun ownership rates, however, do not have higher murder or suicide rates than those with lower gun ownership. Indeed many high gun ownership nations have much lower murder rates. Consider, for example, the wide divergence in murder rates among Continental European nations with widely divergent gun ownership rates.

The non-correlation between gun ownership and murder is reinforced by examination of statistics from larger numbers of nations across the developed world. Comparison of "homicide and suicide mortality data for thirty-six nations (including the United States) for the period 1990–1995" to gun ownership levels showed "no significant (at the 5% level) association between gun ownership levels and the total homicide rate."[41] Consistent with this is a later European study of data from 21 nations in which "no significant correlations [of gun ownership levels] with total suicide or homicide rates were found."[42]

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37. *See* Delbert S. Elliott, *Life-Threatening Violence is* Primarily *a Crime Problem: A Focus on Prevention*, 69 COLO. L. REV. 1081, 1089 (1998) (emphasis added).

38. *See infra* Part III.

39. *See supra* notes 3–9 and Table 1.

40. *See supra* Table 1 and *infra* Tables 2–3.

41. KLECK, *supra* note 8, at 254. The study also found no correlation to suicide rates. *Id.*

42. Martin Killias et al., *Guns, Violent Crime, and Suicide in 21 Countries*, 43 CAN. J. CRIMINOLOGY & CRIM. JUST. 429, 430 (2001). It bears emphasis that the authors, who are deeply anti-gun, emphasize the "very strong correlations between the presence of guns in the home and *suicide committed with a gun*"—as if there were some import

II. ASKING THE WRONG QUESTION

However unintentionally, the irrelevance of focusing on weaponry is highlighted by the most common theme in the more guns equal more death argument. Epitomizing this theme is a World Health Organization (WHO) report asserting, "The easy availability of firearms has been associated with higher *firearm* mortality rates."[43] The authors, in noting that the presence of a gun in a home corresponds to a higher risk of suicide, apparently assume that if denied firearms, potential suicides will decide to live rather than turning to the numerous alternative suicide mechanisms. The evidence, however, indicates that denying one particular means to people who are motivated to commit suicide by social, economic, cultural, or other circumstances simply pushes them to some other means.[44] Thus, it is not just the murder rate in gun-less Russia that is four times higher than the American rate; the Russian suicide rate is also about four times higher than the American rate.[45]

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to the death being by gun rather than by hanging, poison, or some other means. *Id.*; *see also infra* Part III.

43. WORLD HEALTH ORGANIZATION, SMALL ARMS AND GLOBAL HEALTH 11 (2001) (emphasis added). This irrelevancy is endlessly repeated. *See, e.g.*, Wendy Cukier, *Small Arms and Light Weapons: A Public Health Approach*, 9 BROWN J. WORLD AFF. 261, 266, 267 (2002) ("Research has shown that rates of *small arms* death and injury are linked to small arms accessibility . . . . In industrialized countries, studies have shown that accessibility is related to *firearm* death rates . . . . Other approaches have examined the rates of death *from firearms* across regions, cities, high income countries, and respondents to victimization surveys." (emphasis added) (internal citations omitted); *see also* Neil Arya, *Confronting the Small Arms Pandemic* 324 BRITISH MED. J. 990 (2002); E.G. Krug et al., *Firearm-Related Deaths in the United States and 35 Other High and Upper-Middle-Income Countries*, 27 INT'L J. EPIDEMIOLOGY 214 (1988).

44. *See* JACOBS, *supra* note 11, at 120 ("[I]f the Brady Law did have the effect of modestly reducing firearms suicides . . . this effect was completely offset by an increase of the same magnitude in nonfirearm suicide" resulting in the same number of deaths); *see also* KLECK, *supra* note *8*, at 265–92 (summarizing and reviewing studies regarding guns and suicide). Indeed, though without noting the significance, the WHO report states that out of sample of 52 countries, "firearms accounted for only one-fifth of all suicides, just ahead of poisoning . . . . [Self-] strangulation, [i.e. hanging] was the most frequently used method of suicide." WORLD HEALTH ORGANIZATION, *supra* note 43, at 3.

45. In 1999, the latest year for which we have Russian data, the American suicide rate was 10.7 per 100,000 people, while the Russian suicide rate was almost 41 per 100,000 people. William Alex Pridemore & Andrew L. Spivak, *Patterns of Suicide Mortality in Russia*, 33 SUICIDE & LIFE-THREATENING BEHAVIOR 132, 133 (2003); Donna L. Hoyert et al., *Deaths: Final Data for 1999*, NAT'L VITAL STAT. REP., Sept. 21, 2001, at 6.

There is no social benefit in decreasing the availability of guns if the result is only to increase the use of other means of suicide and murder, resulting in more or less the same amount of death. Elementary as this point is, proponents of the more guns equal more death mantra seem oblivious to it. One study asserts that Americans are more likely to be shot to death than people in the world's other 35 wealthier nations.[46] While this is literally true, it is irrelevant—except, perhaps to people terrified not of death per se but just death by gunshot. A fact that should be of greater concern—but which the study fails to mention—is that per capita murder *overall* is only half as frequent in the United States as in several other nations where *gun* murder is rarer, but murder by strangling, stabbing, or beating is much more frequent.[47]

Of course, it may be speculated that murder rates around the world would be higher if guns were more available. But there is simply no evidence to support this. Like any speculation, it is not subject to conclusive disproof; but the European data in Table 1 and the studies across 36 and 21 nations already discussed show no correlation of high gun ownership nations and greater murder per capita or lower gun ownership nations and less murder per capita.[48]

To reiterate, the determinants of murder and suicide are basic social, economic, and cultural factors, not the prevalence of some form of deadly mechanism. In this connection, recall that the American jurisdictions which have the highest violent crime rates are precisely those with the most stringent gun controls.[49] This correlation does not necessarily

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46. *See* Krug et al., *supra* note 42, at 218–19.

47. *Id.* at 216. Two of those nations, Brazil and Estonia, had more than twice the overall murder rates of the United States. David C. Stolinsky, *America: The Most Violent Nation?*, 5 MED. SENTINEL 199, 200 (2000). Readers may question the value of comparing the United States to those particular nations; however, this comparison was first suggested by Krug. Krug et al., *supra* note 43, at 215 (using thirty-six countries, having among the highest GNP per capita as listed in the World Bank's 1994 World Development Report). All we have done is provide full murder rate information for these comparisons.

48. KLECK, *supra* note 8, at 254; Killias et al., *supra* note 41, at 430.

49. *See infra* notes 128-30 and accompanying text. For at least thirty years, gun advocates have echoed in more or less identical terms the observation that twenty percent of American homicide is concentrated in four cities with the nation's most restrictive gun laws. *See Firearms Legislation: Hearing Before the Subcomm. on Crime of the H. Comm. on the Judiciary*, 94th Cong. 2394 (1975) (statement of Neal Knox). In October 2000, the head of a gun advocacy group ridiculed a Handgun Control

prove gun advocates' assertion that gun controls actually encourage crime by depriving victims of the means of self-defense. The explanation of this correlation may be political rather than criminological: jurisdictions afflicted with violent crime tend to severely restrict gun ownership. This, however, does not suppress the crime, for banning guns cannot alleviate the socio-cultural and economic factors that are the real determinants of violence and crime rates. [50]

Table 2: Murder Rates of European Nations that Ban Handguns as Compared to Their Neighbors that Allow Handguns
(rates are per 100,000 persons)

Nation	Handgun Policy	Murder Rate	Year
A. Belarus	banned	10.40	late 1990s
[Neighboring countries with gun law and murder rate data available]			
Poland	allowed	1.98	2003
Russia	banned	20.54	2002
B. Luxembourg	banned	9.01	2002
[Neighboring countries with gun law and murder rate data available]			
Belgium	allowed	1.70	late 1990s
France	allowed	1.65	2003
Germany	allowed	0.93	2003
C. Russia	banned	20.54	2002
[Neighboring countries with gun law and murder rate data available]			
Finland	allowed	1.98	2004
Norway	allowed	0.81	2001

Notes: This table covers all the European nations for which the information given is available. As in Table 1, the homicide rate data comes from an annually published report, CANADIAN CENTRE FOR JUSTICE STATISTICS, HOMICIDE IN CANADA, JURISTAT.

Once again, we are not arguing that the data in Table 2 shows that gun control *causes* nations to have much higher

"scorecard" for its misleading attempts to inversely correlate violent crime rates to the extent of the various states' gun controls. He points out that, in fact, the states with the most restrictive gun laws consistently have higher murder rates than states with less restrictive laws, while those with the least controls had the lowest homicide rates. Larry Pratt, HCI Scorecard (2000), http://gunowners.org/op0042.htm; *see also infra* note 131.

50. It is noteworthy that the correlation between more gun control and more crime seems to hold true in other nations, though much less strikingly than in the United States. *See* Miron, *supra* note 30, at 628.

murder rates than neighboring nations that permit handgun ownership. Rather, we assert a political causation for the observed correlation that nations with stringent gun controls tend to have much higher murder rates than nations that allow guns. The political causation is that nations which have violence problems tend to adopt severe gun controls, but these do not reduce violence, which is determined by basic socio-cultural and economic factors.

The point is exemplified by the conclusions of the premier study of English gun control. Done by a senior English police official as his thesis at the Cambridge University Institute of Criminology and later published as a book, it found (as of the early 1970s), "Half a century of strict controls . . . has ended, perversely, with a far greater use of [handguns] in crime than ever before." [51] The study also states that:

> No matter how one approaches the figures, one is forced to the rather startling conclusion that the use of firearms in crime was very much less [in England before 1920] when there were no controls of any sort and when anyone, convicted criminal or lunatic, could buy any type of firearm without restriction.[52]

Of course the point of this analysis is not that the law should allow lunatics and criminals to own guns. The point is that violence will be rare when the basic socio-cultural and economic determinants so dictate; and conversely, crime will rise in response to changes in those determinants—without much regard to the mere availability of some particular weaponry or the severity of laws against it.

III. DO ORDINARY PEOPLE MURDER?

The "more guns equal more death" mantra seems plausible only when viewed through the rubric that murders mostly involve ordinary people who kill because they have access to a firearm when they get angry. If this were true, murder might well increase where people have ready access to firearms, but the available data provides no such correlation. Nations and

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51. COLIN GREENWOOD, FIREARMS CONTROL: A STUDY OF ARMED CRIME AND FIREARMS CONTROL IN ENGLAND AND WALES 243 (1972).

52. *Id.*

areas with more guns per capita do not have higher murder rates than those with fewer guns per capita.[53]

Nevertheless, critics of gun ownership often argue that a "gun in the closet to protect against burglars will most likely be used to shoot a spouse in a moment of rage . . . . *The problem is you and me—law-abiding folks*;"[54] that banning handgun possession only for those with criminal records will "fail to protect us from the most likely source of handgun murder: ordinary citizens;"[55] that "most gun-related homicides . . . are the result of impulsive actions taken by individuals *who have little or no criminal background* or who are known to the victims;"[56] that "the majority of firearm homicide[s occur] . . . not as the result of criminal activity, but because of arguments between people who know each other;"[57] that each year there are thousands of gun murders "by law-abiding citizens who might have *stayed* law-abiding if they had not possessed firearms."[58]

These comments appear to rest on no evidence and actually contradict facts that have so uniformly been established by homicide studies dating back to the 1890s that they have become "criminological axioms."[59] Insofar as studies focus on perpetrators, they show that neither a majority, nor many, nor virtually any murderers are ordinary "law-abiding citizens."[60] Rather, almost all murderers are extremely aberrant individuals with life histories of violence, psychopathology, substance abuse, and other dangerous behaviors. "The vast majority of persons involved in life-threatening violence have a long criminal record with many prior contacts with the justice system."[61] "Thus homicide—[whether] of a

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53. *See supra* Tables 1–2 and notes 10–15; *see infra* Table 3 and notes 125–127.

54. David Kairys, *A Carnage in the Name of Freedom*, PHILADELPHIA INQUIRER, Sept. 12, 1988, at A15 (emphasis added), *quoted in* Frank J. Vandall, *A Preliminary Consideration of Issues Raised in the Firearms Sellers Immunity Bill*, 38 AKRON L. REV. 113, 118 n.28 (2005).

55. Nicholas Dixon, *Why We Should Ban Handguns in the United States*, 12 ST. LOUIS U. PUB. L. REV. 243, 265–66 (1993) (emphasis added), *quoted* in Vandall, *supra* note 54, at 119, n.32.

56. ROBERT J. SPITZER, THE POLITICS OF GUN CONTROL 147 (3rd ed. 1995) (emphasis added).

57. Violence Policy Center, Who Dies? A Look at Firearms Death and Injury in America, http://www.vpc.org/studies/whointro.htm (last visited Nov. 17, 2006).

58. Natl Coalition to Ban Handguns, *supra* note 21 (emphasis added).

59. *See* David M. Kennedy & Anthony J. Braga, *Homicide in Minneapolis: Research for Problem Solving*, 2 HOMICIDE STUD. 263, 267 (1998).

60. *See* Elliott, *supra* note 37, at 1093.

61. *Id*.

stranger or [of] someone known to the offender—'is usually part of a pattern of violence, engaged in by people who are known . . . as violence prone.'"[62] Though only 15% of Americans over the age of 15 have arrest records,[63] approximately 90 percent of "*adult* murderers have *adult* records, with an average adult criminal career [involving crimes committed as an adult rather than a child] of six or more years, including four major *adult* felony arrests."[64] These national statistics dovetail with data from local nineteenth and twentieth century studies. For example: victims as well as offenders [in 1950s and 1960s Philadelphia murders] . . . tended to be people with prior police records, usually for violent crimes such as assault."[65] "The great majority of both perpetrators and victims of [1970s Harlem] assaults and murders had previous [adult] arrests, probably over 80% or more."[66] Boston police and probation officers in the 1990s agreed that of those juvenile-perpetrated murders where all the facts were known, virtually all were committed by gang members, though the killing was not necessarily gang-directed. [67] One example would be a gang member who stabs his girlfriend to death in a fit of anger.[68] Regardless of their arrests for other crimes, 80% of 1997 Atlanta murder arrestees had at least one earlier drug offense with 70% having 3 or more prior drug offenses.[69] A *New York Times* study of the 1,662 murders committed in that city in the years 2003–2005 found that "[m]ore than 90 percent of the killers had criminal records."[70] Baltimore police figures show that "92 percent of murder suspects had [prior] criminal records in 2006."[71] Several of the more recent homicide studies just reviewed

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62. GERALD D. ROBIN, VIOLENT CRIME AND GUN CONTROL 48 (1991) (quoting Gary Kleck, *The Assumptions of Gun Control*, *in* FIREARMS AND VIOLENCE 23, 43 (Don B. Kates ed., 1984)).

63. Mark Cooney, *The Decline of Elite Homicide*, 35 CRIMINOLOGY 381, 386 (1997).

64. GARY KLECK & DON B. KATES, ARMED: NEW PERSPECTIVES ON GUN CONTROL 20 (2001).

65. ROGER LANE, MURDER IN AMERICA: A HISTORY 259 (1997).

66. A. SWERSKEY & E. ENLOE, HOMICIDE IN HARLEM 17 (1975).

67. Anthony A. Braga et al., *Youth Homicide in Boston: An Assessment of Supplementary Homicide Report Data*, 3 HOMICIDE STUDIES 277, 283–84 (1999).

68. *See id*.

69. Dean G. Rojek, *The Homicide and Drug Connection*, *in* THE VARIETIES OF HOMICIDE AND ITS RESEARCH: PROCEEDINGS OF THE 1999 MEETING OF THE HOMICIDE RESEARCH WORKING GROUP 128 (P.H. Blackman et al. eds., 2000) [hereinafter THE VARIETIES OF HOMICIDE].

70. Jo Craven McGinty, *New York Killers, and Those Killed, by the Numbers*, N.Y. TIMES, April 28, 2006, at A1.

71. Gus G. Sentementes, *Patterns Persist in City Killings*, BALTIMORE SUN, Jan. 1, 2007, at A1.

were done at the Kennedy School of Government at Harvard and found almost all arrested murderers to have earlier arrests.[72]

That murderers are not ordinary, law-abiding responsible adults is further documented in other sources. Psychological studies of juvenile murderers variously find that at least 80%, if not all, are psychotic or have psychotic symptoms.[73] Of Massachusetts domestic murderers in the years 1991–1995, 73.7% had a "prior [adult] criminal history," 16.5% had an active restraining order registered against them at the time of the homicide, and 46.3% of the violent perpetrators had had a restraining order taken out against them sometime before their crime.[74]

This last study is one of many exposing the false argument that a significant number of murders involve ordinary people killing spouses in a moment of rage. Although there are many domestic homicides, such murders do not occur frequently in ordinary families, nor are the murderers ordinary, law-abiding adults. "The day-to-day reality is that most family murders are prefaced by a long history of assaults."[75] One study of such murders found that "a history of domestic violence was present in 95.8%" of cases.[76] These findings are a routine feature of domestic homicide studies: "[domestic] partner homicide is most often the final outcome of chronic women battering";[77] based on a study from Kansas City, 90% of all the family homi-

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72. Anthony A. Braga et al., *Understanding and Preventing Gang Violence: Problem Analysis and Response Development in Lowell, Massachusetts*, 9 POLICE Q. 20, 29–31 (2006) ("Some 95% of homicide offenders, 82% of aggravated assault offenders, 65% of homicide victims, and 45% of aggravated gun assault victims were arraigned at least once in Massachusetts courts before they committed their crime or were victimized. Individuals that were previously known to the criminal justice system were involved in a wide variety of offenses and, on average, committed many prior crimes . . . . On average, aggravated gun assault offenders had been arraigned for 12 prior offenses, homicide offenders had been arraigned for 9 prior offenses . . . .").

73. Wade C. Myers & Kerrilyn Scott, *Psychotic and Conduct Disorder Symptoms in Juvenile Murderers*, 2 HOMICIDE STUD. 160, 161–62 (1998).

74. Linda Langford et al., *Criminal and Restraining Order Histories of Intimate Partner-Related Homicide Offenders in Massachusetts, 1991-1995*, *in* THE VARIETIES OF HOMICIDE, supra note 69, at 51, 55, 59.

75. Murray A. Straus, *Domestic Violence and Homicide Antecedents*, 62 BULL. N.Y. ACAD. MED. 446, 454 (1986); *see also* Murray A. Straus, *Medical Care Costs of Intrafamily Assault and Homicide*, 62 BULL. N.Y. ACAD. MED. 556, 557 (1986).

76. Paige Hall Smith et al., *Partner Homicide in Context*, 2 HOMICIDE STUD. 400, 410 (1998) (reporting cases only where there was sufficient background information on the parties).

77. *Id.* at 411.

cides were preceded by previous disturbances at the same address, with a median of 5 calls per address."[78]

The only kind of evidence cited to support the myth that most murderers are ordinary people is that many murders arise from arguments or occur in homes and between acquaintances.[79] These bare facts are only relevant if one assumes that criminals do not have acquaintances or homes or arguments. Of the many studies belying this, the broadest analyzed a year's national data on gun murders occurring in homes and between acquaintances. It found "the most common victim-offender relationship" was "where both parties . . . knew one another because of prior illegal transactions."[80]

Thus the term "acquaintance homicide" does not refer solely to murders between ordinary acquaintances. Rather it encompasses, for example: drug dealers killed by competitors or customers, gang members killed by members of the same or rival gangs, and women killed by stalkers or abusers who have brutalized them on earlier occasions, all individuals for whom federal and state laws already prohibit gun possession.[81]

Obviously there are certain people who should not be allowed to own any deadly instrument. Reasonable as such prohibitions are, it is unrealistic to think those people will comply with such restrictions any more readily than they do with laws against violent crime.[82] In any event, studies analyzing ac-

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78. ROBIN, *supra* note 62, at 47–48; *see also* Kathryn E. Moracco et al., *Femicide in North Carolina, 1991-1993*, 2 HOMICIDE STUD. 422, 441 (1998).

79. *See, e.g.*, SPITZER, *supra* note 56; Jeremiah A. Barondess, Letter to the Editor, *Firearm Violence and Public Health*, 272 J. AM. MED. ASS'N 1406, 1409 (1994) (responding to criticism of his article, Karl P. Adler et al., *Firearm Violence and Public Health: Limiting the Availability of Guns*, 271 J. AM. MED. ASS'N 1281 (1994)); Kairys, *supra* note 54.

80. KLECK, *supra* note 8, at 236 (analyzing the U.S. Bureau of Justice Statistics data on murder defendants being prosecuted in 33 U.S. urban counties).

81. Current federal law prohibits gun possession by minors, drug addicts, and persons who have been involuntarily committed to mental institutions or convicted of felonies or domestic violence misdemeanors. 18 U.S.C. § 922(g) (2000). As to state gun laws, see, for example, CAL. PENAL CODE §§ 12021, 12072, 12101, 12551 (Deering 2006). For a summary of the general patterns of federal and state gun laws, see JACOBS, *supra* note 11, at 19–35.

82. *See* WRIGHT ET AL., *supra* note 11, at 137–38 ("[T]here is no good reason to suppose that people intent on arming themselves for criminal purposes would not be able to do so even if the general availability of firearms to the larger population were sharply restricted. Here it may be appropriate to recall the First Law of Economics, a law whose operation has been sharply in evidence in the case of Prohibition, marijuana and other drugs, prostitution, pornography, and a host of other banned arti-

quaintance homicide suggest there is no reason for laws prohibiting gun possession by ordinary, law-abiding responsible adults because such people virtually never murder. If one accepts that such adults are far more likely to be victims of violent crime than to commit it, disarming them becomes not just unproductive but counter-productive.[83]

IV. MORE GUNS, *LESS* CRIME?

Anti-gun activists are not alone in their belief that widespread firearm ownership substantially affects violent crime rates. The same understanding also characterizes many pro-gun activists. Of course, pro-gun activists' belief leads them to the opposite conclusion: that widespread firearm ownership reduces violence by deterring criminals from confrontation crimes and making more attractive such nonconfrontation crimes as theft from unoccupied commercial or residential premises. Superficially, the evidence for this belief seems persuasive. Table 1, for instance, shows that Denmark has roughly half the gun ownership rate of Norway, but a 50% higher murder rate, while Russia has only one-ninth Norway's

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cles and substances—namely, that demand creates its own supply. There is no evidence anywhere to show that reducing the availability of firearms *in general* likewise reduces their availability to persons with criminal intent, or that persons with criminal intent would not be able to arm themselves under any set of general restrictions on firearms.").

83. This Article will not discuss the defensive use of firearms beyond making the following observations: while there is a great deal of controversy about the subject, it is a misleading controversy in which anti-gun advocates' deep ethical or moral objections to civilian self-defense are presented in the guise of empirical argument. The empirical evidence unquestionably establishes that gun ownership by prospective victims not only allows them to resist criminal attack, but also deters violent criminals from attacking them in the first place. See JOSEPH F. SHELEY & JAMES D. WRIGHT, IN THE LINE OF FIRE: YOUTHS, GUNS, AND VIOLENCE IN URBAN AMERICA 63 (1995), and JAMES D. WRIGHT & PETER H. ROSSI, ARMED AND CONSIDERED DANGEROUS: A SURVEY OF FELONS AND THEIR FIREARMS 154 (1986) for a discussion of Dept. of Justice-funded surveys of incarcerated adult and juvenile felons. *See also* LOTT, THE BIAS AGAINST GUNS, *supra* note 30, at 8–11, 227–40; David B. Kopel, *Lawyers, Guns, and Burglars*, 43 ARIZ. L. REV. 345 (2001); Lawrence Southwick, Jr., *Self-Defense with Guns: The Consequences*, 28 J. CRIM. JUST. 351 (2000).

The legitimate question is not *whether* victim gun possession allows for self-defense and deters criminal violence, but how extensive and important these benefits are. *See* KLECK & KATES, *supra* note 64, at 213–342; LOTT, *supra* note 11; Philip J. Cook & Jens Ludwig, *Defensive Gun Uses: New Evidence from a National Survey*, 14 J. QUANTITATIVE CRIMINOLOGY 111 (1998); Philip J. Cook & Jens Ludwig, *Guns in America: National Survey on Private Ownership and Use of Firearms*, Nat'l Inst. Just.: Research in Brief (U.S. Dep't of Justice, Washington, D.C., 1997); Marvin E. Wolfgang, *A Tribute to a View I Have Opposed*, 86 J. CRIM. L. & CRIMINOLOGY 188 (1995).

gun ownership rate but a murder rate 2500% higher. Looking at Tables 1–3, it is easy to find nations in which very high gun ownership rates correlate with very low murder rates, while other nations with very low gun ownership rates have much higher murder rates. Moreover, there is not insubstantial evidence that *in the United States* widespread gun availability has helped reduce murder and other violent crime rates. On closer analysis, however, this evidence appears uniquely applicable to the United States.

More than 100 million handguns are owned in the United States[84] primarily for self-defense,[85] and 3.5 million people have permits to carry concealed handguns for protection.[86] Recent analysis reveals "a great deal of self-defensive use of firearms" in the United States, "in fact, more defensive gun uses [by victims] than crimes committed with firearms."[87] It is little wonder that the

> National Institute of Justice surveys among prison inmates find that large percentages report that their fear that a victim might be armed deterred them from confrontation crimes. "[T]he felons most frightened 'about confronting an armed victim' were those from states with the greatest relative number of privately owned firearms." Conversely, robbery is highest in states that most restrict gun ownership.[88]

Concomitantly, a series of studies by John Lott and his coauthor David Mustard conclude that the issuance of millions of permits to carry concealed handguns is associated with drastic declines in American homicide rates.[89]

Ironically, to detail the American evidence for widespread defensive gun ownership's deterrent value is also to raise questions about how applicable that evidence would be even to the other nations that have widespread gun ownership but low violence. There are no data for foreign nations comparable to the American data just discussed. Without such data, we cannot know whether millions of Norwegians own handguns and carry them for protec-

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84. Kates, *supra* note 29, at 63.

85. KLECK, *supra* note 8, at 74 (collecting survey responses).

86. Kates, *supra* note 29, at 64.

87. JACOBS, *supra* note 11, at 14 (collecting studies).

88. Kates, *supra* note 29, at 70 (collecting studies).

89. LOTT, *supra* note 11; John R. Lott & David B. Mustard, *Crime, Deterrence, and Right-to-Carry*, 26 J. LEGAL STUD. 1 (1997); David B. Mustard, *Culture Affects Our Beliefs About Firearms, But Data are Also Important*, 151 U. PENN. L. REV. 1387 (2003). These studies are highly controversial. See Kates, *supra* note 29, at 70–71, for discussion of critics and criticisms.

tion, thereby deterring Norwegian criminals from committing violent crimes. Nor can we know whether guns are commonly kept for defense in German homes and stores, thus preventing German criminals from robbing them.

Moreover, if the deterrent effect of gun ownership accounts for low violence rates in high gun ownership nations other than the United States, one wonders why that deterrent effect would be amplified there. Even with the drop in United States murder rates that Lott and Mustard attribute to the massive increase in gun carry licensing, the United States murder rate is still eight times higher than Norway's—even though the U.S. has an almost 300% higher rate of gun ownership. That is consistent with the points made above. Murder rates are determined by socio-economic and cultural factors. In the United States, those factors include that the number of civilian-owned guns nearly equals the population—triple the ownership rate in even the highest European gun-ownership nations—and that vast numbers of guns are kept for personal defense. That is not a factor in other nations with comparatively high firearm ownership. High gun ownership may well be a factor in the recent drastic decline in American homicide. But even so, American homicide is driven by socio-economic and cultural factors that keep it far higher than the comparable rate of homicide in most European nations.

In sum, though many nations with widespread gun ownership have much lower murder rates than nations that severely restrict gun ownership, it would be simplistic to assume that at all times and in all places widespread gun ownership depresses violence by deterring many criminals into nonconfrontation crime. There is evidence that it does so in the United States, where defensive gun ownership is a substantial socio-cultural phenomenon. But the more plausible explanation for many nations having widespread gun ownership with low violence is that these nations never had high murder and violence rates and so never had occasion to enact severe anti-gun laws. On the other hand, in nations that have experienced high and rising violent crime rates, the legislative reaction has generally been to enact increasingly severe antigun laws. This is futile, for reducing gun ownership by the law-abiding citizenry—the only ones who obey gun laws—does not reduce violence or murder. The result is that high crime nations that ban guns to reduce crime end up having both high crime and stringent gun laws, while it appears that low crime nations that do not significantly restrict guns continue to have low violence rates.

Thus both sides of the gun prohibition debate are likely wrong in viewing the availability of guns as a major factor in the incidence of murder in any particular society. Though many people may still cling to that belief, the historical, geographic, and demographic evidence explored in this Article provides a clear admonishment. Whether gun availability is viewed as a cause or as a mere coincidence, the long term macrocosmic evidence is that gun ownership spread widely throughout societies consistently correlates with stable or declining murder rates. Whether causative or not, the consistent international pattern is that more guns equal *less* murder and other violent crime. Even if one is inclined to think that gun availability is an important factor, the available international data cannot be squared with the mantra that more guns equal more death and fewer guns equal less death. Rather, if firearms availability does matter, the data consistently show that the way it matters is that more guns equal *less* violent crime.

V. GEOGRAPHIC, HISTORICAL AND DEMOGRAPHIC PATTERNS

If more guns equal more death and fewer guns equal less death, it should follow, all things being equal, (1) that geographic areas with higher gun ownership should have more murder than those with less gun ownership; (2) that demographic groups with higher gun ownership should be more prone to murder than those with less ownership; and (3) that historical eras in which gun ownership is widespread should have more murder than those in which guns were fewer or less widespread. As discussed earlier, these effects are not present. Historical eras, demographic groups, and geographic areas with more guns do not have more murders than those with fewer guns. Indeed, those with more guns often, or even generally, have fewer murders.

Of course, all other things may not be equal. Obviously, many factors other than guns may promote or reduce the number of murders in any given place or time or among particular groups. And it may be impossible even to identify these factors, much less to take account of them all. Thus any conclusions drawn from the kinds of evidence presented earlier in this paper must necessarily be tentative.

Acknowledging this does not, however, blunt the force of two crucial points. The first regards the burden of proof. Those who assert the mantra, and urge that public policy be based on it, bear the burden of proving that more guns do equal more death and fewer guns equal less death. But they cannot bear that burden because there simply is no large number of cases in which the widespread prevalence of guns among the general population has led to more murder. By the same token, but even more importantly, it cannot be shown consistently that a reduction in the number of guns available to the general population has led to fewer deaths. Nor is the burden borne by *speculating* that the reason such cases do not appear is that other factors always intervene.

The second issue, allied to the burden of proof, regards plausibility. On their face, the following facts from Tables 1 and 2 suggest that gun ownership is irrelevant, or has little relevance, to murder: France and neighboring Germany have exactly the same, comparatively high rate of gun ownership, yet the French murder rate is nearly twice the German; France has infinitely more gun ownership than Luxembourg, which nevertheless has a murder rate five times greater, though handguns are illegal and other types of guns sparse; Germany has almost double the gun ownership rate of neighboring Austria yet a similarly very low murder rate; the Norwegian gun ownership rate is over twice the Austrian rate, yet the murder rates are almost identical.

And then there is Table 3, which shows Slovenia, with 66% more gun ownership than Slovakia, nevertheless has roughly one-third less murder per capita; Hungary has more than 6 times the gun ownership rate of neighboring Romania but a lower murder rate; the Czech Republic's gun ownership rate is more than 3 times that of neighboring Poland, but its murder rate is lower; Poland and neighboring Slovenia have exactly the same murder rate, though Slovenia has over triple the gun ownership per capita.

Table 3: Eastern Europe Gun Ownership and Murder Rates
(rates given are per 100,000 people and in descending order)

Nation	Murder Rate	Rate of Gun Ownership
Russia	20.54* [2002]	4,000
Moldova	8.13** [2000]	1,000
Slovakia	2.65** [2000]	3,000
Romania	2.50** [2000]	300
Macedonia	2.31** [2000]	16,000
Hungary	2.22† [2003]	2,000
Finland	1.98‡ [2004]	39,000
Poland	1.79† [2003]	1,500
Slovenia	1.81** [2000]	5,000
Cz. Republic	1.69** [2000]	5,000
Greece	1.12† [2003]	11,000

Notes: This table covers all the Eastern European nations for which we have data regarding both gun ownership and murder rates. Gun ownership data comes from GRADUATE INSTITUTE OF INTERNATIONAL STUDIES, SMALL ARMS SURVEY (2003).

* CANADIAN CENTRE FOR JUSTICE STATISTICS, HOMICIDE IN CANADA, 2002, JURISTAT at 3.

** United Nations Office on Drugs and Crime, *The Seventh United Nations Survey on Crime Trends and the Operations of Criminal Justice Systems (1998–2000)*, Mar. 31, 2004, at 82, 260, 287, 370, 405, 398.

† CANADIAN CENTRE FOR JUSTICE STATISTICS, HOMICIDE IN CANADA, 2003, JURISTAT at 3.

‡ CANADIAN CENTRE FOR JUSTICE STATISTICS, HOMICIDE IN CANADA, 2004, JURISTAT at 3.

On their face, Tables 1, 2, and 3 and the comparisons gleaned from them suggest that gun ownership is irrelevant, or has little relevance, to murder. Historical and demographic comparisons offer further evidence. Again, all the data may be misleading. It is conceivable that more guns do equal more murder, but that this causation does not appear because some unidentifiable extraneous factor always intervenes. That is conceivable, but ultimately unlikely. As Hans Toch, a senior American criminologist who 35 years ago endorsed handgun prohibition and confiscation, but then recanted based on later research, argues "it is hard to explain that where firearms are most dense, violent crime rates are lowest and where guns are least dense, violent crime rates are highest."[90]

90. Toch & Lizotte, *supra* note 11, at 232. Professor Toch was a consultant to the 1960s Eisenhower Commission, and until the 1990s he endorsed its conclusions that

A. Demographic Patterns

Contrary to what should be the case if more guns equal more death, there are no "consistent indications of a link between gun ownership and criminal or violent behavior by owners;" in fact, gun ownership is "higher among whites than among blacks, higher among middle-aged people than among young people, higher among married than among unmarried people, higher among richer people than poor"—all "patterns that are the reverse of the way in which criminal behavior is distributed."[91]

These conclusions are reinforced by focusing on patterns of African-American homicide. Per capita, African-American murder rates are much higher than the murder rate for whites.[92] If more guns equal more death, and fewer guns equal less, one might assume gun ownership is higher among African-Americans than among whites, but in fact African-American gun ownership is markedly lower than white gun ownership.[93]

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widespread handgun ownership causes violence and that reducing ownership would reduce violence. Franklin Zimring, one of the architects of those conclusions, has admitted that they were made speculatively and essentially without an empirical basis. FRANKLIN E. ZIMRING & GORDON HAWKINS, THE CITIZEN'S GUIDE TO GUN CONTROL xi-xii (1987) ("In the 1960s after the assassinations of President John F. Kennedy, Dr. Martin Luther King, Jr., and Senator Robert F. Kennedy, it [gun control] became a major subject of public passion and controversy . . . [sparking a debate that] has been heated, acrimonious and polarized . . . . It began in a factual vacuum [in which] . . . neither side felt any great need for factual support to buttress foregone conclusions. *In the 1960s, there was literally no scholarship on the relationship between guns and violence and the incidence or consequences of interpersonal violence, and no work in progress*." (emphasis added)).

As for the findings of the subsequent body of research, Professor Toch has written:

> [W]hen used for protection firearms can seriously inhibit aggression and can provide a psychological buffer against the fear of crime. Furthermore, the fact that national patterns show little violent crime where guns are most dense implies that guns do not elicit aggression in any meaningful way . . . . Quite the contrary, these findings suggest that high saturations of guns in places, or something correlated with that condition, inhibit illegal aggression.

Id. at 234 & n.10.

91. KLECK, *supra* note 8, at 71.

92. *See* MALCOLM, *supra* note 10, at 232–33; Alfred Blumstein, *Youth Violence, Guns, and the Illicit-Drug Industry*, 86 J. CRIM. L. & CRIMINOLOGY 10, 21 (1995).

93. *See* LOTT, *supra* note 11, at 39 ("[W]hite gun ownership exceed[ed] that for blacks by about 40 in 1996"); *see also* KLECK, *supra* note 8, at 71.

Particularly corrosive to the mantra are the facts as to rural African-Americans gun ownership. Per capita, rural African-Americans are much more likely to own firearms than are urban African-Americans.[94] Yet, despite their greater access to guns, the firearm murder rate of young rural black males is a small fraction of the firearm murder rate of young urban black males.[95]

These facts are only anomalous in relation to the mantra that more guns equal more death and fewer guns equal less death. In contrast, these facts accord with the earlier point regarding the aberrance of murderers. Whatever their race, ordinary people simply do not murder. Thus preventing law-abiding, responsible African-Americans from owning guns does nothing at all to reduce murderers, because they are not the ones who are doing the killing. The murderers are a small minority of extreme antisocial aberrants *who manage to obtain guns whatever the level of gun ownership in the African American community.*

Indeed, murderers generally fall into a group some criminologists have called "violent predators," sharply differentiating them not only from the overall population but from other criminals as well.[96] Surveys of imprisoned felons indicate that when not imprisoned the ordinary felon averages perhaps 12 crimes per year.[97] In contrast, "violent predators" spend much or most of their time committing crimes, averaging at least 5 assaults, 63 robberies, and 172 burglaries annually.[98] A National Institute of Justice survey of 2,000 felons in 10 state prisons, which focused on gun crime, said of these types of respondents:

> [T]he men we have labeled Predators were clearly omnibus felons . . . [committing] more or less any crime they had the opportunity to commit . . . . The Predators (handgun and shotgun combined) . . . amounted to about 22% of the sample and yet accounted for 51% of the total crime [admitted by the 2,000 felons] . . . . Thus, when we talk about "control-

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94. *See* LOTT, *supra* note 11, at 39; *see also* KLECK, *supra* note 8, at 71.

95. The murder rate of young urban African Americans is roughly 600% higher than that of their rural counterparts. *See* Lois A. Fingerhut et al., *Firearm and Nonfirearm Homicide Among Persons 15 Through 19 Years of Age*, 267 J. AM. MED. ASS'N 3048, 3049 tbl.1.

96. JAN M. CHAIKEN & MARCIA R. CHAIKEN, VARIETIES OF CRIMINAL BEHAVIOR 62–63 (1982).

97. *Id*. at 65.

98. *Id*. at 123, 125, 219 tbl.A.19.

> ling crime" in the United States today, we are talking largely about controlling the behavior of these men.[99]

The point is not just that demographic patterns of homicide and gun ownership in the African-American community do not support the more guns equal more death mantra. More importantly, those patterns refute the logic of fewer guns equal less death. The reason fewer guns among ordinary African-Americans does not lead to fewer murders is because that paucity does not translate to fewer guns for the aberrant minority who do murder. The correlation of very high murder rates with low gun ownership in African-American communities simply does not bear out the notion that disarming the populace as a whole will disarm and prevent murder by potential murderers.

B. Macro-historical Evidence: From the Middle Ages to the 20th Century

The Middle Ages were a time of notoriously brutal and endemic warfare. They also experienced rates of ordinary murder almost double the highest recorded U.S. murder rate.[100] But Middle Age homicide "cannot be explained in terms of the availability of firearms, which had not yet been invented."[101] The invention provides some test of the mantra. If it is true that more guns equal more murder and fewer guns equal less death, murder should have risen with the invention, increased efficiency, and greater availability of firearms across the population.

Yet, using England as an example, murder rates seem to have fallen sharply as guns became progressively more efficient and widely owned during the five centuries after the invention of firearms.[102] During much of this period, because the entire adult male population of England was deemed to constitute a militia, every military age male was required to possess arms for use in militia training and service.[103]

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99. WRIGHT & ROSSI, *supra* note 83, at 76.

100. LANE, *supra* note 65, at 14.

101. *Id*. at 151. *See generally id*. ch. 1.

102. MALCOLM, *supra* note 10, at 19–20.

103. *See generally* JOYCE LEE MALCOLM, TO KEEP AND BEAR ARMS: THE ORIGINS OF AN ANGLO-AMERICAN RIGHT 1–15 (1994); STEPHEN P. HALBROOK, THAT EVERY MAN BE ARMED: THE EVOLUTION OF A CONSTITUTIONAL RIGHT 37–53 (1984); Don B. Kates, *Handgun Prohibition and the Original Meaning of the Second Amendment*, 82 MICH. L. REV. 204, 214–16 (1983).

The same requirement was true in America during the period of colonial and post-colonial settlement. Indeed, the basic English militia laws were superceded by the colonies' even more specific and demanding legal requirements of *universal* gun ownership. Under those laws, virtually all colonists and every household were required to own guns. Depending on the colony's laws, male youths were deemed of military age at 16, 17, or 18, and every military age man, except for the insane, infirm, and criminals, had to possess arms. They were subject to being called for inspection, militia drill, or service, all of which legally required them to bring and present their guns. To arm those too poor to afford guns, the laws required that guns be purchased for them and that they make installment payments to pay back the cost.[104]

It bears emphasis that these gun ownership requirements were not limited to those subject to militia service. Women, seamen, clergy, and some public officials were automatically exempt from militia call up, as were men over the upper mili-

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104. MALCOLM, *supra* note 103, at 138–41; Kates, *supra* note 102, at 214–16. Typical laws (quoted with original spelling and punctuation) appear from the following sources: ARCHIVES OF MARYLAND 77 (William Hand Browne ed., Baltimore, Maryland Historical Society 1883) ("[T]hat every house keeper or housekeepers within this Province shall have ready continually upon all occasions within his her or their house for him or themselves and for every person within his her or their house able to bear armes one Serviceable fixed gunne of bastard muskett boare" along with a pound of gunpowder, four pounds of pistol or musket shot, "match for match locks and of flints for firelocks"); NARRATIVES OF EARLY VIRGINIA 273 (Lyon Gardiner Tyler ed., photo. reprint 1974) (1907) (requiring that everyone attend church on Sunday, further providing that "all suche as beare armes shall bring their pieces swordes, poulder and shotte" with them to church on penalty of a fine); RECORDS OF THE GOVERNOR AND COMPANY OF THE MASSACHUSETTS BAY IN NEW ENGLAND 84 (Nathaniel B. Shurtleff ed., Boston, William White 1853) (ordering towns to provide their residents with arms if they could not provide their own "for the present, & after to receive satisfaction for that they disburse when they shall be able"); RECORDS OF THE COLONY OF RHODE ISLAND AND PROVIDENCE PLANTATIONS, IN NEW ENGLAND 79-80, 94 (John Russell Bartlett ed., Providence, A. Crawford Greene & Brother, 1856) (requiring, respectively: "[T]hat every man do come armed unto the meeting upon every sixth day," and also that militia officers go "to every inhabitant [in Portsmouth and] see whether every one of them has powder" and bullets; and "that noe man shall go two miles from the Towne unarmed, eyther with Gunn or Sword; and that none shall come to any public Meeting without his weapon."); THE CODE OF 1650, BEING A COMPILATION OF THE EARLIEST LAWS AND ORDERS OF THE GENERAL COURT OF CONNECTICUT 72 (Hartford, Silas Andrus 1822) ("That all persons that are above the age of sixteene yeares, except magistrates and church officers, shall beare arms . . . and every male person within this jurisdiction, above the said age, shall have in continuall readines, a good muskitt or other gunn, fitt for service, and allowed by the clark of the band.").

tary age, which varied from 45 to 60, depending on the colony. But every household was required to have a gun, even if all its occupants were otherwise exempt from militia service, to deter criminals and other attackers. Likewise, all respectable men were theoretically required to carry arms when out and abroad.[105]

These laws may not have been fully enforced (except in times of danger) in areas that had been long-settled and peaceful. Nevertheless, "by the eighteenth century, colonial Americans were the most heavily armed people in the world."[106] Yet, far from more guns equaling more death, murders in the New England colonies were "rare," and "few" murderers in all the colonies involved guns "despite their wide availability."[107]

America remained very well armed yet homicide remained quite low for over two hundred years, from the earliest settlements through the entire colonial period and early years of the United States. Homicide in more settled areas only began rising markedly in the two decades before the Civil War.[108] By that time the universal militia was inoperative and the universality of American gun ownership had disappeared as many people in long-settled peaceful areas did not hunt and had no other need for a firearm.[109]

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105. For collections of many of the relevant laws, see Clayton E. Cramer, Gun Control in Colonial New England, (unpublished manuscript, available at http://www.claytoncramer.com/GunControlColonialNewEngland.PDF) (last visited Nov. 19, 2006); Clayton E. Cramer, Gun Control in Colonial New England, Part II (unpublished manuscript, available at http://www.claytoncramer.com/GunControlColonialNewEngland2.PDF) (last visited Nov. 19, 2006); Clayton E. Cramer, Gun Control in the Middle & Southern Colonies, (unpublished manuscript, available at http://www.claytoncramer.com/MiddleSouthernColonialGunControl.PDF) (last visited Nov. 19, 2006); Clayton E. Cramer, Militia Statutes, http://www.claytoncramer.com/primary.html#MilitiaLaws (last visited Nov. 19, 2006).

106. JOHN MORGAN DEDERER, WAR IN AMERICA TO 1775, at 116 (1990).

107. LANE, *supra* note 64, at 48, 59–60.

108. *Id.* at 344.

109. The enthusiasm modern gun advocates express for the ancient militia far exceeds the enthusiasm felt by the Englishmen and Americans who were actually subject to the obligations involved. Guns were expensive items even for those owners who were supplied them by the colonies since they were required to pay the colonies back over time. And the duty of militia drill was a constant source of irritation to men who had little time for leisure and urgent need to devote their time to making a living for themselves and their families. By the turn of the nineteenth century, at the earliest, the universal militia was in desuetude and replaced in the 1840s

The Civil War acquainted vast numbers of men with modern rapid-fire guns, and, in its aftermath, provided a unique opportunity to acquire them. Before the Civil War, reliable multi-shot rifles or shotguns did not exist and revolvers (though they had been invented in the 1830s) were so expensive they were effectively out of reach for most of the American populace.[110] The Civil War changed all that. Officers on both sides had to buy their own revolvers, while sidearms were issued to noncommissioned officers generally, as well as those ordinary soldiers who were in the artillery, cavalry, and dragoons.[111] The fact that over two million men served in the Union Army at various times while the Confederates had over half that number suggests the number of revolvers involved.[112]

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by colorfully garbed volunteer formations whose activities were more social than military.

110. Revolver inventor Samuel Colt's first business failed in 1840. It revived itself only with sales to officers and the military during the Mexican-American War (1846–1848), and sustained itself through the 1850s with sales to wealthy Americans and Europeans. *See* JOSEPH G. BILBY, CIVIL WAR FIREARMS 157 (1996); LEE KENNETT & JAMES LAVERNE ANDERSON, THE GUN IN AMERICA 90 (1975); LANE, *supra* note 65, at 109. Colt's sales flourished as foreign armies adopted his revolver and wide sales took place in the commercial market across Europe, KENNETT & ANDERSON, *supra*, at 90, especially after Colt's prize-winning exhibit at the 1851 Great Industrial Exhibition in London. *See generally* JOSEPH G. ROSA, COLONEL COLT LONDON 13–29 (1976).

111. *See generally* BILBY, *supra* note 110, at 157–72. The revolvers involved were by no means all Colts: "[T]he Federal government also purchased large numbers of Remington, Starr and Whitney revolvers, as well as the guns of other [American] makers, including the bizarre looking Savage, with its second 'ring trigger' which cocked the arm, and the sidehammer Joslyn." *Id.* at 158. Vast numbers of guns were also purchased in Europe where, in the first 15 months of the war, the Union bought over 738,000 firearms (including long arms as well as revolvers). ALLAN R. MILLETT & PETER MASLOWSKI, FOR THE COMMON DEFENSE: A MILITARY HISTORY OF THE UNITED STATES OF AMERICA 216 (1984). Some Union infantry units were issued revolvers and many enlisted infantrymen in other units bought their own. BILBY, *supra* note 110, at 160.

112. These figures are just estimates. While at least somewhat reliable figures exist for how many men served at any one time in the Union Army, that number is not co-extensive with how many served in total. Some Union soldiers served throughout the war, re-enlisting when their original enlistments were up. Others mustered out and were replaced with new recruits. Still others deserted long before their terms were up, again requiring replacements. Some scoundrels enlisted just for the enlistment bonus, and deserted as soon as they could; some of these went through the enlistment and desertion process multiple times, collecting a new bonus under a new name time after time. THE WORLD ALMANAC AND BOOK OF FACTS 2006, at 77 (2006) gives figures of 2,128,948 for the Union Army and 84,415 for the Marines; it estimates that the Confederate Army's size was between 600,000 to 1,500,000.

At war's end, the U.S. Army and Navy were left with vast numbers of surplus revolvers, both those they had purchased and those captured from Confederate forces. As the Army plummeted to slightly over 11,000 men,[113] hundreds of thousands of military surplus revolvers were sold at very low prices. In addition, when their enlistments were up, or when they were mustered out at war's end, former officers and soldiers retained hundreds of thousands of both revolvers and rifles. These commandeered arms included many of the new repeating rifles the Union had bought (over the fervent objections of short-sighted military procurement officers) at the command of President Lincoln, who had tested the Spencer rifle himself. After his death the Army reverted to the single-shot rifle, disposing of all its multi-shots at surplus and thereby ruining Spencer by glutting the market.[114]

Thus over the immediate post-Civil War years "the country was awash with military pistols" and rifles of the most modern design.[115] The final three decades of the century saw the introduction and marketing of the "two dollar pistol," which were very cheap handguns manufactured largely out of pot metal.[116] In addition to being sold locally, such "suicide specials" were marketed nationwide through Montgomery Ward catalogs starting in 1872 and by Sears from 1886.[117] They were priced as low as $1.69, and were marketed under names like the "Little Giant" and the "Tramp's Terror."[118]

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113. RUSSELL F. WEIGLEY, HISTORY OF THE UNITED STATES ARMY 262 (1967) ("The names of 1,000,516 officers and men were on the [Union Army's] rolls on May 10, 1865; by [the end of 1866, the draft had ended and] . . . only 11,043 volunteers remained . . . .").

114. KENNETT & ANDERSON, *supra* note 110, at 92–93.

115. DAVID T. COURTWRIGHT, VIOLENT LAND: SINGLE MEN AND SOCIAL DISORDER FROM THE FRONTIER TO THE INNER CITY 42 (1996).

116. KENNETT & ANDERSON, *supra* note 110, at 99.

117. *Id.* at 98–99.

118. *Id.* at 98–100. An 1879 issue of *Scientific American* contains an advertisement for COD purchasing of the $2.75 "Czar" revolver, presumably an attempt to capitalize on the Smith & Wesson "Russian," a very high quality weapon that Smith & Wesson manufactured for the Russian government and sold through the 1870s. SCI. AM., June 14, 1879, at 381. The 1884 Price List-Firearms Catalog for N. Curry & Brother, arms dealers of San Francisco, lists prices from $2.00 for the 7 shot "Fashion" and "Blue Jacket" revolvers to $2.50 and $3.50 for the "Kitemaug" and "Ranger" revolvers to various Colt and Smith & Wesson revolvers selling at from $15.00 to $17.00. KENNETT & ANDERSON, *supra* note 110, at 98–100.

Thus, the period between 1866 and 1900 saw a vast diffusion of commercial and military surplus revolvers and lever action rifles throughout the American populace. Yet, far from rising, homicide seems to have fallen off sharply during these thirty years.

Whether or not guns were the cause, homicide steadily declined over a period of five centuries coincident with the invention of guns and their diffusion throughout the continent. In America, from the seventeenth century through the early nineteenth century, murder was rare and rarely involved guns, though gun ownership was universal by law and "colonial Americans were the most heavily armed people in the world."[119] By the 1840s, gun ownership had declined but homicide began a spectacular rise through the early 1860s. From the end of the Civil War to the turn of the twentieth century, however, America in general, and urban areas in particular, such as New York, experienced a tremendous spurt in ownership of higher capacity revolvers and rifles than had ever existed before, but the number of murders sharply declined.[120]

In sum, the notion that more guns equal more death is not borne out by the historical evidence available for the period between the Middle Ages and the twentieth century. Yet this conclusion must be viewed with caution. While one may describe broad general trends in murder rates and in the availability of firearms, it is not possible to do so with exactitude. Not until the late 1800s in England, and the mid-1900s in the United States were there detailed data on homicide. Information about the distribution of firearms is even more sparse. For instance, Lane's generalizations about the rarity of gun murders and low American murder rates in general are subject to some dispute. Professor Randolph Roth, for example, has shown that early American murder rates and the extent to which guns were used in murder varied greatly between differing areas and time periods.[121]

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119. DEDERER, *supra* note 106, at 116.

120. *See* LANE, *supra* note 65, at 181, 307; ERIC H. MONKKONEN, MURDER IN NEW YORK CITY 21, 30–31, 38 (2001).

121. Randolph Roth, *Guns, Gun Culture, and Homicide: The Relationship Between Firearms, the Uses of Firearms, and Interpersonal Violence*, 59 WM. & MARY Q. 223, 234–40 (2002).

C. Later and More Specific Macro-Historical Evidence

Malcolm presents reliable trend data on both gun ownership and crime in England for the period between 1871 and 1964. Significantly, these trend data do not at all correlate as the mantra would predict: violent crime did not increase with increased gun ownership nor did it decline in periods in which gun ownership was lower.[122]

In the United States, the murder rate doubled in the ten-year span between the mid-1960s and the mid-1970s. Since this rise coincided with vastly increasing gun sales, it was viewed by many as proof positive that more guns equal more death. That conclusion, however, does not follow. It is at least equally possible that the causation was reversed: that is, the decade's spectacular increases in murder, burglary, and all kinds of violent crimes caused fearful people to buy guns.[123] The dubiousness of assuming that the gun sales caused the rise in murder rather than the reverse might have been clearer had it been known in this period that virtually the same murder rate increase was occurring in gun-less Russia.[124] Clearly there is little basis to assume guns were the reason for the American murder rate rise when the Russian murder rate exhibited the same increase without a similar increase in the number of guns.

Reliable information on both gun ownership and murder rates in the United States is available only for the period commencing at the end of World War II. Significantly, the decade from the mid-1960s to the mid-1970s is a unique exception to the general pattern that, decade-by-decade, the number of guns owned by civilians has risen steadily and

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122. *See* MALCOLM, *supra* note 10, app. at 258. The handgun ownership data cited are tax data and so doubtless fail to count the pistols owned by criminals and others who failed to pay taxes. The extremely low numbers of gun crimes, however, do not support the notion that there were numerous criminal owners of guns, or at least that they used the guns for crime.

123. In contrast to the more guns equal more death mantra, studies suggest that crime rate increases fuel gun buying, rather than the other way around. *See, e.g.*, Douglas C. Bice & David D. Hemley, *The Market for New Handguns: An Empirical Investigation*, 45 J.L. & ECON. 251, 253, 261–262 (2002); Lawrence Southwick, Jr., *Do Guns Cause Crime? Does Crime Cause Guns? A Granger Test*, 25 ATLANTIC ECON. J. 256, 256, 272 (1997); KLECK, *supra* note 8, at 79–81.

124. In 1965, the Russian homicide rate stood at 5.9 per 100,000 population while the American rate was 5.4. As of 1975, both Russian and American rates had nearly doubled, the Russian to 10.3 and the American to 9.7. *See* Pridemore, *supra* note 2, at 272 fig.2; *see also supra* note 6 and accompanying text.

dramatically but murder rates nevertheless have remained stable or even declined. As for the second half of the twentieth century, and especially its last quarter, a study comparing the number of guns to murder rates found that during the 25-year period from 1973 to 1997, the number of handguns owned by Americans increased 160% while the number of all firearms rose 103%. Yet over that period, the murder rate declined 27.7%.[125] It continued to decline in the years 1998, 1999, and 2000, despite the addition in each year of two to three million handguns and approximately five million firearms of all kinds. By the end of 2000, the total American gunstock stood at well over 260 million—951.1 guns for every 1,000 Americans—but the murder rate had returned to the comparatively low level prior to the increases of the mid-1960s to mid-1970s period.[126]

In sum, the data for the decades since the end of World War II also fails to bear out the more guns equal more death mantra. The per capita accumulated stock of guns has increased, yet there has been no correspondingly consistent increase in either total violence or gun violence. The evidence is consistent with the hypothesis that gun possession levels have little impact on violence rates.[127]

D. Geographic Patterns within Nations

Once again, if more guns equal more death and fewer guns equal less death, areas within nations with higher gun ownership should in general have more murders than those with less gun ownership in a similar area. But, in fact, the reverse pattern prevails in Canada,[128] "England, America, and Switzerland, [where the areas] with the highest rates of gun ownership were in fact those with the lowest rates of violence."[129]

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125. Don B. Kates & Daniel D. Polsby, *Long-Term Nonrelationship of Widespread and Increasing Firearm Availability to Homicide in the United States*, 4 HOMICIDE STUD. 185, 190–91 (2000).

126. *See* communication from Gary Kleck, Professor, Florida State University, to Don B. Kates and Gary Mauser (Feb. 26, 2003) (on file with Authors).

127. KLECK, *supra* note 8, at 17–19.

128. *See* Philip C. Stenning, *Gun Control: A Critique of Current Policy*, POL'Y OPTIONS, Oct. 1994, at 13, 15.

129. MALCOLM, *supra* note 10, at 204; *see also* BBC News, *Handgun Crime 'Up' Despite Ban*, July 16, 2001, http://news.bbc.co.uk/2/hi/uk_news/1440764.stm (noting that English areas with very low numbers of firearms have higher than average gun crime while areas with the highest levels of legally held guns do not).

A recent study of all counties in the United States has again demonstrated the lack of relationship between the prevalence of firearms and homicide.[130]

This inverse correlation is one of several that seems to contradict more guns equal more death. For decades the gun lobby has emphasized that, in general, the American jurisdictions where guns are most restricted have consistently had the highest violent crime rates, and those with the fewest restrictions have the lowest violent crime rates.[131] For instance, robbery is highest in jurisdictions which are most restrictive of gun ownership.[132]As to one specific control, the ban on carrying concealed weapons for protection, "violent-crime rates were highest in states [that flatly ban carrying concealed weapons], next highest in those that allowed local authorities discretion [to deny] permits, and lowest in states with nondiscretionary" concealed weapons laws under which police are legally required to license every qualified applicant.[133] Also of interest are the extensive opinion surveys of incarcerated felons, both juvenile and adult, in which large percentages of the felons replied that they often feared potential victims might be armed and aborted violent crimes because of that fear.[134] The felons most frightened about confronting an armed victim were those "from states with the greatest relative number of privately owned firearms."[135]

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130. Tomislav Kovandzic, Mark E. Schaffer, & Gary Kleck, *Gun Prevalence, Homicide Rates and Causality: A GMM Approach to Endogeneity Bias* 39–40 (Ctr. for Econ. Policy Research, Discussion Paper No. 5357, 2005) *available at* http://ssrn.com/abstract=878132.

131. *See e.g.*, National Rifle Association Institute for Legislative Action (NRA-ILA), More Guns, Less Crime (Sept. 26, 2006), http://www.nraila.org/Issues/FactSheets/Read.aspx?idequals206&issueequals007; NRA-ILA, The War Against Handguns (Feb. 15, 2001), www.nraila.org/Issues/FactSheets/Read.aspx?idequals17; NRA-ILA, Right-to-Carry 2006 (Oct. 3, 2006), www.nraila.org/Issues/FactSheets/Read.aspx?idequals18; NRA-ILA, The Brady Handgun Violence Prevention Act, Does it Live Up to its Name? (July 28, 1999), www.nraila.org/Issues/FactSheets/Read.aspx?idequals73.

132. *See, e.g.*, Philip J. Cook, *The Effect of Gun Availability on Robbery and Robbery Murder: A Cross Section Study of Fifty Cities*, 3 POL'Y STUD. REV. ANN. 743, 770 (1979).

133. LOTT, *supra* note 11, at 43.

134. WRIGHT & ROSSI, *supra* note 83, at 147, 150.

135. *Id.* at 151.

E. Geographic Comparisons: European Gun Ownership and Murder Rates

This topic has already been addressed at some length in connection with Tables 1–3, which contain the latest data available. Tables 4–6, contain further, and somewhat more comprehensive, data from the early and mid-1990s.[136] These statistics reinforce the point that murder rates are determined by basic socio-cultural and economic factors rather than mere availability of some particular form of weaponry. Consider Norway and its neighbors Sweden, the Netherlands, and Denmark. Norway has far and away Western Europe's highest household gun ownership rate (32%), but also its lowest murder rate. The Netherlands has the lowest gun ownership rate in Western Europe (1.9%), and Sweden lies midway between (15.1%) the Netherlands and Norway. Yet the Dutch gun murder rate is higher than the Norwegian, and the Swedish rate is even higher, though only slightly.[137]

Table 4: Intentional Deaths: United States vs. Continental Europe Rates

In order of highest combined rate; nations having higher rates than the United States are indicated by asterisk (suicide rate) or + sign (murder rate).

Nation	Suicide	Murder	Combined rates
Russia	41.2*	30.6+	71.8
Estonia	40.1*	22.2+	62.3
Latvia	40.7*	18.2+	58.9
Lithuania	45.6*	11.7+	57.3
Belarus	27.9*	10.4+	38.3
Hungary	32.9*	3.5	36.4
Ukraine	22.5*	11.3+	33.8
Slovenia	28.4*	2.4	30.4
Finland	27.2*	2.9	30.1
Denmark	22.3*	4.9	27.2
Croatia	22.8*	3.3	26.1
Austria	22.2*	1.0	23.2
Bulgaria	17.3*	5.1	22.4
France	20.8*	1.1	21.9
Switzerland	21.4*	1.1‡	24.1

136. Tables 4–6 were previously published as appendices to Kates, *supra* note 81, app. at 81 tbl.1, 82 tbl.2, 83 tbl.3.

137. *See infra* Table 5.

Belgium	18.7*	1.7	20.4
United States	11.6	7.8	19.4
Poland	14.2*	2.8	17.0
Germany	15.8*	1.1	16.9
Romania	12.3*	4.1	16.4
Sweden	15.3*	1.0	16.3
Norway	12.3*	0.8	13.1
Holland	9.8	1.2	11.0
Italy	8.2	1.7	9.9
Portugal	8.2	1.7	9.9
Spain	8.1	0.9	9.0
Greece	3.3	1.3	4.6

Notes: Data based in general on U.N. DEMOGRAPHIC YEARBOOK (1998) as reported in David C. Stolinsky, *America: The Most Violent Nation?* 5 MED. SENTINEL 199–201 (2000). It should be understood that, though the 1998 Yearbook gives figures for as late as 1996, the figures are not necessarily for that year. The Yearbook contains the latest figure each nation has provided the U.N., which may be 1996, 1995, or 1994.

‡ The Swiss homicide figure that Stolinsky reports is an error because it combines attempts with actual murders. We have computed the Swiss murder rate by averaging the 1994 and 1995 Swiss National Police figures for actual murders in those years given in RICHARD MUNDAY & JAN A. STEVENSON, GUNS AND VIOLENCE: THE DEBATE BEFORE LORD CULLEN 268 (1996).

Table 5: European Gun/Handgun Violent Death

Nation	Suicide with handgun	Murder with handgun	Percent of households with guns	Percent of households with handguns
Belgium	18.7	1.7	16.6%	6.8%
France	20.8	1.1	22.6%	5.5%
West Germany	15.8	1.1	8.9%	6.7%*
Holland	9.8	1.2	1.9%	1.2%
Italy	8.2	1.7	16.0%	5.5%
Norway	12.3	0.8	32%%	3.8%
Sweden	15.3	1.3	15.1%	1.5%
Switzerland	20.8	1.1**	27.2%	12.2%

Notes: For derivation of the homicide rates, see notes to Table 4. The data on household firearms ownership come from British Home Office figures printed in RICHARD MUNDAY & JAN A. STEVENSON, GUNS AND VIOLENCE: THE DEBATE BEFORE LORD CULLEN 30, 275 (1996).

* Note that the data here are for *West* Germany and were obtained when that nation still existed as an independent entity. See *infra* Tables 1 & 4 for later (but differently derived) data for the current nation of Germany.

** Again, the Swiss homicide figure that Stolinsky reports is an error because it combines attempts with actual murders. *See* notes for Table 4.

Table 6: European Firearms-Violent Deaths

Nation	Suicide	Suicide with gun	Murder	Murder with gun	Number of guns per 100,000 population
Austria	N/A	N/A	2.14	0.53	41.02*
Belarus	27.26	N/A	9.86	N/A	16.5
Czech Rep.	9.88	1.01	2.80	0.92	27.58
Estonia	39.99	3.63	22.11	6.2	28.56
Finland	27.28	5.78	3.25	0.87	411.20**
Germany	15.80	1.23	1.81	0.21	122.56
Greece	3.54	1.30	1.33	0.55	77.00
Hungary	33.34	0.88	4.07	0.47	15.54
Moldova	N/A	N/A	17.06	0.63	6.61
Poland	14.23	0.16	2.61	0.27	5.30
Romania	N/A	N/A	4.32	0.12	2.97
Slovakia	13.24	0.58	2.38	0.36	31.91
Spain	5.92	N/A	1.58	0.19	64.69
Sweden	15.65	1.95	1.35	0.31	246.65

Notes: It bears emphasis that the following data come from a special U.N. report whose data are not fully comparable to those in Tables 4 and 5 because they cover different years and derive from substantially differing sources.[138] This special report is based on data obtained from the governments of the nations set out below, especially data on gun permits or other official indicia of gun ownership in those nations.[139] The data on suicide and murder in those

138. The data derive from a much more extensive survey of legal firearms ownership in numerous nations which was carried out by researchers provided by the Government of Canada under the auspices of the United Nations Economic and Social Council, Commission on Crime Prevention and Criminal Justice in 1997. The entire survey is published as a report to the Secretary General on April 25, 1997 as E/CN.15/1997/4. That report is analysed in some detail in an unpublished paper ("A Cross Sectional Study of the Relationship Between Levels of Gun Ownership and Violent Deaths") written by the leading English student of firearms regulation, retired Chief Superintendent of English police Colin Greenwood of the Firearms Research and Advisory Service. We are indebted to Chief Superintendent Greenwood for the opportunity to review his paper. Note that in the table which follows we have focused only on European nations.

139. The gun ownership data in Table 4 derive from a random telephone survey on gun ownership in various nations. Chief Superintendent Greenwood's paper is contemptuous of such data, in part because people may be unwilling to acknowledge owning guns to telephoning pollsters. For similar doubts see Don B. Kates & Daniel D. Polsby, *Long Term Non-Relationship of Firearm Availability to Homicide*, 4 HOMICIDE STUD. 185–201 (2000). But that was in the context of comparing survey data on the number of guns owned to production and important data that are unquestionably more comprehensive and superior in every way. Chief Superintendent Greenwood himself admits that the special U.N. report data are not necessarily

nations also come from their governments as do the similar data in Tables 4 and 5, but for later years, and also include data on the number of firearm homicides and firearm suicides which are not available from the U.N. source used in Tables 4 and 5.

* This may well be an undercount because an Austrian license is not limited to a single firearm but rather allows the licensee to possess multiple guns.

** The source from which Table 5 derives also gives figures for Finland, which we have omitted there because they are earlier and closely similar except in one respect: instead of official ownership figures for guns, they give a survey-based figure for households having a gun: 23.2%.

These comparisons are reinforced by Table 6, which gives differently derived (and non-comparable) gun ownership rates, overall murder rates, and rates of gun murder, for a larger set of European nations.[140] Table 6 reveals that even though Sweden has more than double the rate of gun ownership as neighboring Germany, as well as more gun murders, it has 25% less murder overall. In turn, Germany, with three times the gun ownership rate of neighboring Austria, has a substantially lower murder rate overall and a lower gun murder rate. Likewise, though Greece has over twice the per capita gun ownership rate of the Czech Republic, Greece has substantially less gun murder and less than half as much murder overall. Although Spain has over 12 times more gun ownership than Poland, the latter has almost a third more gun murder and more overall murder than the former. Finally, Finland has 14 times more gun ownership than neighboring Estonia, yet Estonia's gun murder and overall murder rates are about seven times higher than Finland's.

F. Geographic Comparisons: Gun Ownership and Suicide Rates

The mantra more guns equal more death and fewer guns equal less death is also used to argue that "limiting access to firearms could prevent many suicides."[141] Once again, this assertion is di-

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comprehensive and are problematic in various other respects. Even assuming they are clearly superior to the survey data, the latter cover multiple nations that the special U.N. report does not. Given that neither source is indubitable, it seems preferable to have such information on those nations as the survey data reveal, rather than no data at all.

140. Table 6 covers different years from Table 5, its comparative gun ownership figures derive from government records rather than survey data, and it gives rates for gun murders, data that are not available in the sources from which Table 5 is taken. See the explanatory note that precedes Table 6.

141. Arthur L. Kellermann et al., *Suicide in the Home in Relation to Gun Ownership*, 327 NEW ENG. J. MED. 467, 467, 471–72 (1992); *see also* Antoon Leenaars, et al., *Controlling the Environment to Prevent Suicide: International Perspectives*, 45 CAN. J. PSYCHIATRY 639 (2000).

rectly contradicted by the studies of 36 and 21 nations (respectively) which find no statistical relationship. Overall suicide rates were no worse in nations with many firearms than in those where firearms were far less widespread.[142]

Consider the data about European nations in Tables 5 and 6. Sweden, with over twice as much gun ownership as neighboring Germany and a third more gun suicide, nevertheless has the lower overall suicide rate. Greece has nearly three times more gun ownership than the Czech Republic and somewhat more gun suicide, yet the overall Czech suicide rate is over 175% higher than the Greek rate. Spain has over 12 times more gun ownership than Poland, yet the latter's overall suicide rate is more than double the former's. Tragically, Finland has over 14 times more gun ownership than neighboring Estonia, and a great deal more gun-related suicide. Estonia, however, turns out to have a much higher suicide rate than Finland overall.

There is simply no relationship evident between the extent of suicide and the extent of gun ownership. People do not commit suicide because they have guns available. In the absence of firearms, people who are inclined to commit suicide kill themselves some other way.[143] Two examples seem as pertinent as they are poignant. The first concerns the 1980s increase in suicide among young American males, an increase that, although relatively modest, inspired perfervid denunciations of gun ownership.[144] What these denunciations failed to mention was that suicide of teenagers and young adults was increasing throughout the entire industrialized world, regardless of gun availability, and often much more rapidly than in the United States. The only unusual aspect of suicide in the United States was that it involved guns. The irrelevancy of guns to the increase in American suicide is evident because suicide among English youth actually increased 10 times more

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142. *See* Killias et al., *supra* note 42, at 430 (study of 21 nations); *see generally* KLECK, *supra* note 8.

143. *See* KLECK, *supra* note 8, at ch. 8; *see also* World Health Organization, *supra* note 43, at 3 (showing that around the world "firearms accounted for only one-fifth of all suicides, just ahead of poisoning . . . . [s]trangulation, i.e. (hanging) was the most frequently used method of suicide").

144. *See, e.g.*, Jeffrey H. Boyd & Eve K. Moscicki, *Firearms and Youth Suicide*, 76 AM. J. PUB. HEALTH 1240 (1986); James A. Mercy et al., *Public Health Policy for Preventing Violence*, 12 HEALTH AFF. 7 (1993); Daniel W. Webster & Modena E. H. Wilson, *Gun Violence Among Youth and the Pediatrician's Role in Primary Prevention*, 94 PEDIATRICS 617 (1994); Lois A. Fingerhut & Joel C. Kleinman, *Firearm Mortality Among Children and Youth*, NAT'L CTR HEALTH STAT. ADVANCE DATA, Nov. 3, 1989, at 1.

sharply, with "car exhaust poisoning [being] the method of suicide used most often."[145] By omitting such facts, the articles blaming guns for increasing American suicide evaded the inconvenience of having to explain exactly what social benefit nations with few guns received from having their youth suicides occur in other ways.

Even more poignant are the suicides of many young Indian women born and raised on the island of Fiji. In general, women are much less likely to commit suicide than are men.[146] This statistic is true of Fijian women overall as well, but not of women in the large part of Fiji's population that is of Indian ancestry. As children, these Indian women are raised in more-or-less loving and supportive homes. But upon marriage they are dispersed across the island to remote areas where they live with their husbands' families, an often overtly hostile situation the husbands do little to mitigate. Indian women on Fiji have a suicide rate nearly as high as that of Indian men, a rate many times greater than that of non-Indian Fijian women.[147] It also bears emphasis that the overall Fijian suicide rate far exceeds that of the United States.

The method of suicide is particularly significant. Fijian women of Indian ancestry commit suicide without using guns, perhaps because guns are unavailable. About three-quarters of these women hang themselves, while virtually all the rest die from consuming the agricultural pesticide paraquat. The recommendation of the author whose article chronicles all these suicides is so myopic as to almost caricature the more guns equal more death mindset: to reduce suicide by Indian women, she recommends that the Fijian state stringently control paraquat.[148] Apparently she believes de-

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145. Keith Hawton, *By Their Own Young Hand*, 304 BRIT. MED. J. 1000 (1992); *see also Teenage Deaths Increasing Across Europe*, CRIM. & JUST. INT'L, Nov.–Dec. 1991, at 4.

146. World Health Organization, Suicide Rates by Country, http://www.who.int/mental_health/prevention/suicide/country_reports/en/index.html (follow hyperlinks to specific countries) (last visited Jan. 18, 2007). For example, in the United States, suicide rates for males exceed those for females by a 17.9-4.2 margin (2002 data). In Denmark, the margin is 19.2-8.1 (2001 data); in Austria, the margin is 27.0-8.2 (2004 data); and in Belgium, the margin is 31.2-11.4 (1997 data).

147. *See* Ruth H. Haynes, *Suicide in Fiji: A Preliminary Study*, 145 BRIT. J. PSYCHIATRY 433 (1984).

148. *Id.* at 437. More or less the same situation seems to prevail in the substantially Indian-populated nation of Sri Lanka (formerly Ceylon). It "has one of the highest suicide rates in the world . . . . Suicides are especially frequent among young adults,

creased access to a means of death will reconcile these women to a life situation they regard as unendurable. At the risk of belaboring what should be all too obvious, restricting paraquat will not improve the lives of these poor women. It will only reorient them towards hanging, drowning, or some other means of suicide.

Guns are just one among numerous available deadly instruments. Thus, banning guns cannot reduce the amount of suicides. Such measures only reduce the number of suicides by firearms. Suicides committed in other ways increase to make up the difference. People do not commit suicide because they have guns available. They kill themselves for reasons they deem sufficient, and in the absence of firearms they just kill themselves in some other way.

CONCLUSION

This Article has reviewed a significant amount of evidence from a wide variety of international sources. Each individual portion of evidence is subject to cavil—at the very least the general objection that the persuasiveness of social scientific evidence cannot remotely approach the persuasiveness of conclusions in the physical sciences. Nevertheless, the burden of proof rests on the proponents of the more guns equal more death and fewer guns equal less death mantra, especially since they argue public policy ought to be based on that mantra.[149] To bear that burden would at the very least require showing that a large number of nations with more guns have more death and that nations that have imposed stringent gun controls have achieved substantial reductions in criminal violence (or suicide). But those correlations are not observed when a large number of nations are compared across the world.

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both male and female. Compared to the U.S., the suicide rate for males ages 15 to 24 years in Sri Lanka is nearly four times greater; the female rate nearly 13 times greater. *The most common mode of suicide is ingestion of liquid pesticides*." Lawrence R. Berger, *Suicides and Pesticides in Sri Lanka*, 78 AM. J. PUB. HEALTH 826 (1988) (emphasis added).

149. (1) Those who propose to change the status quo bear the burden of proving that change is a good idea; (2) those who propose a new policy bear the burden of proving that the policy is a good idea; and (3) in a free society those who propose to abolish a personal liberty passionately valued by millions bear the burden of proving that abolishment is a good idea.

Over a decade ago, Professor Brandon Centerwall of the University of Washington undertook an extensive, statistically sophisticated study comparing areas in the United States and Canada to determine whether Canada's more restrictive policies had better contained criminal violence. When he published his results it was with the admonition:

> If you are surprised by [our] finding[s], so [are we]. [We] did not begin this research with any intent to "exonerate" handguns, but there it is—a negative finding, to be sure, but a negative finding is nevertheless a positive contribution. It directs us where not to aim public health resources.[150]

150. Brandon S. Centerwall, *Author's Response to "Invited Commentary: Common Wisdom and Plain Truth,"* 134 AM. J. EPIDEMIOLOGY 1264, 1264 (1991).

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: 20 Mar 2018 08:06:19 -0400
To: Mercy, James (CDC/ONDIEH/NCIPC);Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Ferdon, Corinne (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Fox, Kate (CDC/ONDIEH/NCIPC)
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC);Lenard, Courtney (CDC/ONDIEH/NCIPC)
Subject: FYI: Annals of Internal Medicine editorial on GV research (CDC, IOM report)

http://annals.org/aim/fullarticle/2675740/public-health-research-gun-violence-long-overdue

DEAS AND OPINIONS 20 MARCH 2018

Public Health Research on Gun Violence: Long Overdue

Victor J. Dzau, MD; Alan I. Leshner, PhD

Article, Author, and Disclosure Information

Gun violence is a defining public health challenge of our time. As the United States grapples with the shooting deaths of 17 people in Parkland, Florida, on 14 February 2018, the medical and public health communities must step up and do our share to prevent such devastation from recurring. Effective public health strategies have reduced such threats as motor vehicle injury, tobacco use, accidental poisonings, and drownings. Effective strategies are built on research to identify patterns of risk, illuminate productive targets for intervention, and assess the effectiveness of interventions. Unfortunately, the United States lacks a comprehensive public health approach to gun violence, due in large part to the absence of federal funding for research on gun violence for more than 2 decades. In 2013, after the tragedy at Sandy Hook Elementary School, President Obama directed federal agencies to mount research programs to improve understanding of the causes of gun violence and interventions to reduce it. As a result, the Centers for Disease Control and Prevention (CDC) asked the Institute of Medicine (IOM) and the National Research Council (NRC) to define a public health research agenda for gun violence. The resulting consensus report, "Priorities for Research to Reduce the Threat of Firearm-Related Violence," laid out the highest-priority research questions to effect progress in a 3- to 5-year time frame (1). These recommendations remain relevant and may be even more urgent today. Without research, policymakers are flying blind when they propose new laws or policies.

A provision in a 1996 omnibus spending bill known as the Dickey Amendment forbade the CDC from using its funds to promote or advocate for gun control. This was interpreted as a prohibition on supporting any research on firearms, and the CDC program was dismantled. As a result, we lack even the most basic information about the prevalence and safety of firearms in the United States, as well as data on the effectiveness of interventions aimed at reducing the probability of injury and death related to their use.

The shooting in Parkland has prompted renewed calls for research, including from members of Congress. The 2013 IOM/NRC report provides an immediately actionable blueprint to advance such an agenda. The report notes that public health research should be integrated with insights from criminal justice and other fields because no single agency or research strategy can provide all of the answers. The proposed research agenda focuses on characteristics of firearm violence, risk and

protective factors, interventions and strategies, the effects of gun safety technology, and the influence of video games and other media.

To develop effective strategies to reduce firearm injury and death, it is important to understand what is and what is not known. We lack good data on the number and types of guns in the United States. We need to understand the scope and nature of gun acquisition, ownership, and use across the U.S. population, especially among groups at risk for perpetrating or experiencing gun violence. To protect civil liberties, these data should be collected anonymously. We also need good data on fatal and nonfatal gun incidents, including the proportions that are accidental versus intentional.

Factors that may influence the risk posed by guns range from how securely they are stored to complex predictors at the societal, community, situational, and individual levels. At the individual level, risk for perpetration of gun violence coincides with low educational attainment, substance use, and a history of aggression and abuse. In the home, secure storage of guns and accessibility by children are areas of major concern. At the community level, poverty and drug trafficking are known to increase the risk for violence, and at the societal level, cultural norms that promote violence as an acceptable means of conflict resolution may be harmful. These are just a few of the many factors that may relate to risk for gun violence. Only dedicated research can reveal which of these factors, alone or in combination, are the most promising targets for intervention.

It is important for research agendas to include evaluations of the effectiveness of interventions to prevent gun violence. Recently, various interventions have been proposed or implemented, such as firearm safety education programs or modifications to the physical environment, including installation of metal detectors. However, we lack conclusive evidence about their effectiveness. Policymakers should be wary of potential unintended consequences of untested "solutions."

Firearm technologies may provide an important opportunity to reduce the public health burden of gun-related injury. Like an airbag in a car or a childproof cap on a pill bottle, the objectives of firearm technologies range from preventing unintentional shootings by young children to reducing suicide. The IOM/NRC report argued that research should examine product safety measures. Specifically, the report proposes research to identify the effects of different technologies designed to reduce firearm injury and death and to explore state and international policy approaches to firearm safety technology for applicability to the United States.

Finally, the IOM/NRC report advocated for study of the influence of video games and other media on violence. In more than 50 years of research, no study has focused on real-life firearm violence as a specific outcome of violence in media. As a result, a direct relationship between the two is unproven.

If implemented, the public health research agenda proposed in the 2013 IOM/NRC report would provide knowledge to inform our nation's approach to minimizing firearm-related violence and its effects on the health of the U.S. public. Scientific evidence generated by this research would enable the development of sound policies that support the rights and responsibilities central to gun ownership in the United States. It is time to bring the full power of science to bear to deal with this issue of such great concern to our country. We need researchers from different disciplines, including public health, social and behavioral sciences, mental health, and law enforcement, to work together to tackle this problem. That can only happen if we restore the much-needed research funding. It is time to end the counterproductive research freeze.

From: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: 18 Apr 2016 08:12:48 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Dorigo, Leslie (CDC/ONDIEH/NCIPC);Patterson, Sara S. (CDC/ONDIEH/NCIPC);Greenspan, Arlene (CDC/ONDIEH/NCIPC);Biagioni, Mark T. (CDC/ONDIEH/NCIPC)
Subject: FYI: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690
Attachments: 2353690 Carper Response- Gun Violence Draft v5 (003).docx
Importance: High

FYI...looks like this is final or very near final.

From: Hoffmann, Lauren (CDC/OD/OCS)
Sent: Monday, April 18, 2016 8:04 AM
To: Lubar, Debra (CDC/OCOO/OFR/OA) ; Patterson, Sara S. (CDC/ONDIEH/NCIPC)
Cc: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: FW: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690
Importance: High

Deb – (b)(5)

(b)(5)

Sara– (b)(5)

Lauren

Lauren Hoffmann, MA, BS I Lead, High Profile Action Team, Division of Issues Management, Analysis and Coordination (IMAC) I Office of Chief of Staff I Office of the Director I Centers for Disease Control and Prevention
1600 Clifton Road, NE, Atlanta, GA 30333 I Office: 404-639-7126 I Mobile: 404-547-3997 I E-mail: cpf5@cdc.gov
Forecast. Coordinate. Communicate.

From: Frieden, Thomas (Tom) (CDC/OD)
Sent: Friday, April 15, 2016 6:13 PM
To: Payne, Rebecca L. (CDC/OD/OCS) <rco0@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>; Lubar, Debra (CDC/OCOO/OFR/OA) <dpl9@cdc.gov>
Subject: RE: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

I'm ok w it if Deb is

From: Payne, Rebecca L. (CDC/OD/OCS)
Sent: Friday, April 15, 2016 5:03 PM
To: Frieden, Thomas (Tom) (CDC/OD) <txf2@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>; Lubar, Debra (CDC/OCOO/OFR/OA) <dpl9@cdc.gov>
Subject: RE: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

(b)(5)

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 4 Apr 2016 15:37:20 +0000
To: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Cc: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: Action - please review proposed responses to qs 1-3: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research
Attachments: Carper.docx

Hi Beth –

(b)(5)

Linda

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, April 04, 2016 10:41 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Cc: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: Action - please review proposed responses to qs 1-3: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Linda,

I wanted to give you an opportunity to review our proposed responses to the other questions in the Carper response, which were prepared while you were out. I have included the raw info we received from program and a proposed response which is clearly labeled as such. Please let me know if you have any questions.

1. (b)(5)

(b)(5) (b)(5)

(b)(5)

Proposed response – see additions to the original list in red:

(b)(5)

(b)(5)

2. (b)(5)

Proposed response (b)(5)

(b)(5)

Response from program (b)(5)

(b)(5)

2. (b)(5)

Proposed response (b)(5)

(b)(5)

(b)(5)

(b)(5)

(b)(5)

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 1:15 PM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Could you please check-in with Melissa to see where they are with the draft, when they expect to have it to us for our review and if there is any way we can help now that Linda and I are back in the office?

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 1:12 PM
To: Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Ok- let me know how I can help fix this. Sorry it has gotten so messy- I didn't mean to mess it up.

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 1:06 PM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

(b)(5)

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 1:00 PM
To: Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

(b)(5)

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 12:57 PM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Thanks. Don't worry about it, you are still learning and I should have mentioned in team meeting that I need to see all firearm related content before it goes to the Center. Thanks for this. -Beth

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 12:55 PM
To: Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: Re: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Here is what I sent forward to Melissa who was going to check back with Elizabeth S before I reached back out to Kristen Holland (b)(5)

(b)(5)

We haven't received all the answers back yet for a full review, which is what I was going to have you and Linda review again. Sorry I didn't know you wanted to review these before I sent back to Elizabeth S. I figured they were ok since Tom reviewed them. Sorry!

From: Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, March 30, 2016 6:33 PM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Hmm.. let me check with ES before you push back. Will let you know. Thank you!

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Wednesday, March 30, 2016 5:49 PM
To: Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Subject: Re: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Hi there!
So sorry this is late! (b)(5)

(b)(5)

(b)(5) the

Thank you!

EBV

From: Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Sent: Monday, March 28, 2016 2:11:32 PM (UTC-05:00) Eastern Time (US & Canada)
To: DVP Policy Requests (CDC)
Subject: FW: For Action Due by 4/1: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

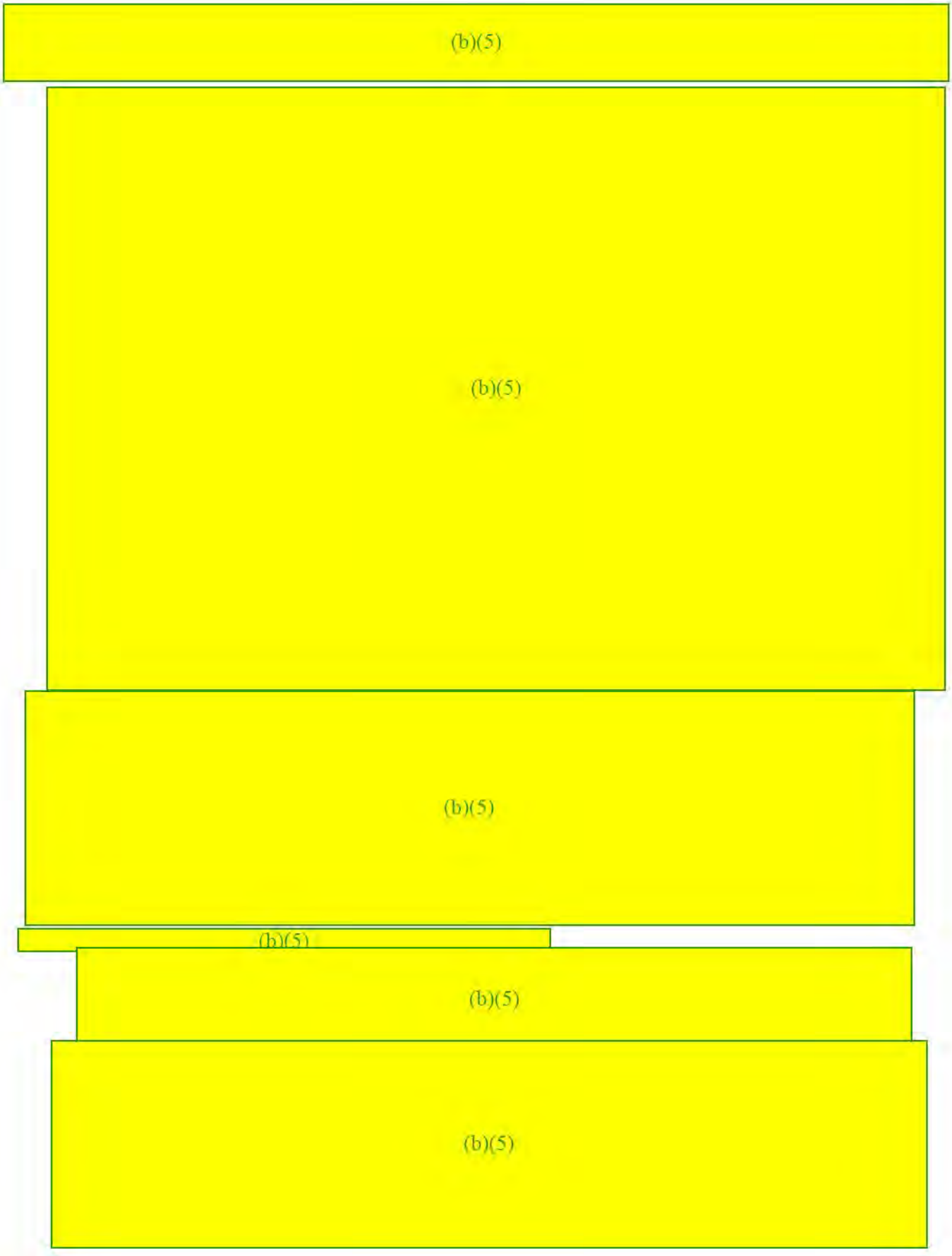
Hi DVP!
I have a couple of questions highlighted for you as we are working on a congressional response to Senator Carper's inquiries. (b)(5) (b)(5) was hoping to get these back by COB Wednesday but let me know if that deadline is not feasible! Thank you so much!

(b)(5)

Here are some others you could add:

(b)(5)

(b)(5)


(b)(5)
(b)(5)
(b)(5)
(b)(5)
(b)(5)
(b)(5)

(b)(5)

Thanks so much for your help!
Best,
Melissa

From: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, March 28, 2016 10:47 AM
To: DVP Policy Requests (CDC) <dvppolicyrequests@cdc.gov>; Williams-Johnson, Mildred M. (CDC/ONDIEH/NCIPC) <mmw1@cdc.gov>; Greenspan, Arlene (CDC/ONDIEH/NCIPC) <aig0@cdc.gov>; Newton, Donovan (CDC/ONDIEH/NCIPC) <ime1@cdc.gov>
Cc: Cattledge, Gwendolyn Ph.D (CDC/ONDIEH/NCIPC) <gxc8@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>; Patterson, Sara S. (CDC/ONDIEH/NCIPC) <afo0@cdc.gov>; Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Asekun, Adeyelu (CDC/ONDIEH/NCIPC) <fpg8@cdc.gov>
Subject: RE: For Action Due by 4/1: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Hi everyone,
Thanks for your continued work on this request. Once I have received all answers, I will compile and send to everyone for (b)(5) review. I have an additional piece that I need your assistance in answering, so please add this to the information you will be sending NLT this Friday.
Question 5 asks:

(b)(5) or

(b)(5)

Thanks and please let me know if you have any questions.
Elizabeth

From: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Wednesday, March 16, 2016 2:38 PM
To: DVP Policy Requests (CDC) <dvppolicyrequests@cdc.gov>; Williams-Johnson, Mildred M. (CDC/ONDIEH/NCIPC) <mmw1@cdc.gov>; Igbo, Tochukwu (CDC/ONDIEH/NCIPC) <tbi0@cdc.gov>; Greenspan, Arlene (CDC/ONDIEH/NCIPC) <aig0@cdc.gov>
Cc: Newton, Donovan (CDC/ONDIEH/NCIPC) <ime1@cdc.gov>; Cattledge, Gwendolyn Ph.D (CDC/ONDIEH/NCIPC) <gxc8@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>; Patterson, Sara S. (CDC/ONDIEH/NCIPC) <afo0@cdc.gov>; Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Asekun, Adeyelu (CDC/ONDIEH/NCIPC) <fpg8@cdc.gov>
Subject: For Action Due by 4/1: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research
Importance: High

Hi everyone,

Attached is a letter from Senator Carper (D-DE) from the Committee on Homeland Security and Governmental Affairs (ranking member). The letter is in reference to firearm violence activities and he poses 11 questions to us that we must respond to by 4/15. Keeping in mind that all questions will have to go through clearance at every level within CDC and HHS, I would like to have responses compiled by no later than April 1st. (b)(5)

(b)(5)

(b)(5) If you feel like I mistakenly assigned a response, please let me know.

7. Each year, CDC's Division of Violence Prevention solicits investigator-initiated research via an "RO 1" Grant Program Announcement. The language in these announcements signals to grant-seeking public health researchers the research priorities of the CDC and its Division of Violence Prevention. Please describe any Division of Violence Prevention's ROI Grant Program Announcements related to gun violence research put forward from 1996 to the present. (b)(5)

8. The National Violent Death Reporting System collects and combines data from multiple sources to provide states and communities with a more complete record of the circumstances surrounding violent deaths. Participation from all 50 states would significantly increase the amount of data available to the National Violent Death Reporting System and, thereby, improve its effectiveness. In how many states has the National Violent Death Reporting System been implemented? How many states have applied to be included in this system? What circumstances have prevented all state applicants from being added to the National Violent Death Reporting System? (b)(5)

9. Has the CDC previously entered into any agreements with the National Rifle Association offering to provide advanced notice of any publication on the subject of gun violence? If so, please provide a description of any such agreements as well as communications and documents memorializing the agreements. (b)(5)

10. From 1996 to the present, has the CDC instructed any employee or researcher to not conduct scientific research on gun violence? Has the CDC instructed any employees or researchers to re-write reports submitted for publication to avoid using any variation of the word "gun"? (b)(5)

(b)(5) all for review.

11. What remedies are available to CDC researchers who believe their scientific research has been inappropriately suppressed or discouraged? Please describe any review or appeals processes and include a list of the offices or review boards who would address any such concerns. (b)(5)

(b)(5)

Thanks,
Elizabeth

Elizabeth Solhtalab, MPA
Legislative & Issues Management Team Lead
Office of Policy and Partnerships
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
p: 770.488.6151
bb: 404.219.8685
ikd9@cdc.gov
I telework on Tuesdays and Thursdays and can be reached via email or blackberry

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, April 04, 2016 10:41 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Cc: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: Action - please review proposed responses to qs 1-3: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Linda,

I wanted to give you an opportunity to review our proposed responses to the other questions in the Carper response, which were prepared while you were out. (b)(5) (b)(5) Please let me know if you have any questions.

1. (b)(5)

2. (b)(5)

Patterson.

Proposed response: (b)(5)

(b)(5)

(b)(5))(5)

(b)(5)

(b)(5) (b)(5)

(b)(5)

Response from program: (b)(5)

(b)(5)

2. (b)(5)

(b)(5) (b)(5)

Proposed response: (b)(5)

(b)(5)

We didn't receive FY 16 funding from NIJ.

(b)(5)

(b)(5)

(b)(5)

(b)(5)

(b)(5)

Comment [DLL1]: (b)(5)

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 1:15 PM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Could you please check-in with Melissa to see where they are with the draft, when they expect to have it to us for our review and if there is any way we can help now that Linda and I are back in the office?

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 1:12 PM
To: Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Ok- let me know how I can help fix this. Sorry it has gotten so messy- I didn't mean to mess it up.

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 1:06 PM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

(b)(5) (b)(5)
(b)(5) (b)(5)
(b)(5)

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 1:00 PM
To: Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

(b)(5)

I sent those both on Weds and have been getting nervous because I didn't hear anything back yet from Elizabeth about either and I think the letter is due today. (b)(5)
(b)(5)

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 12:57 PM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Thanks. Don't worry about it, you are still learning and I should have mentioned in team meeting that I need to see all firearm related content before it goes to the Center. Thanks for this. -Beth

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Friday, April 01, 2016 12:55 PM
To: Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: Re: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Here is what I sent forward to Melissa who was going to check back with Elizabeth S before I reached back out to Kristen Holland (b)(5)

(b)(5)

We haven't received all the answers back yet for a full review, which is what I was going to have you and Linda review again. Sorry I didn't know you wanted to review these before I sent back to Elizabeth S. I figured they were ok since Tom reviewed them. Sorry!

From: Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, March 30, 2016 6:33 PM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Hmm.. let me check with ES before you push back. Will let you know. Thank you!

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Wednesday, March 30, 2016 5:49 PM
To: Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Subject: Re: Action: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Hi there!

So sorry this is late! So I like the answers (below) they gave me for #1 and #2, but #3 I don't think really answers the question. I am going to reach back out and see if I can get a similar answer to #2 for #3. I think they interpreted the request to be about funding $ for 2016, but I interpret to read do we have the 2016 data yet- can you clarify for me before I push back?

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 4 Feb 2016 20:15:39 +0000
To: Mercy, James (CDC/ONDIEH/NCIPC)
Subject: RE: ACTION: Do you have the report mentioned below?

Okay – I'll let Courtney know. Thanks for checking.

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:11 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: ACTION: Do you have the report mentioned below?

I looked and can't find it.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 1:37 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>
Subject: ACTION: Do you have the report mentioned below?
From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 12:20 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Thanks, Linda!

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 12:13 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Not sure about this one – I'll do some digging to see if I can find the report referenced below.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 11:09 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Good morning,
Quick follow up from Kate, do you have a copy of this report or title?
One of the subjects for my story mentioned that in the 1990s, after the CDC Injury Center had produced/funded a number of studies about gun violence, then-CDC Director David Satcher commissioned a panel of outside experts to review that portfolio of work and make sure it wasn't biased toward gun control advocacy. The panel ultimately concluded that the studies weren't biased and were in fact extremely well done, and I was wondering if you knew of a way I could access that report so I could cite it in my article. I would love to get a copy or even the name so I can look it up myself.
Thank you!
Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 6:10 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: Re: For Review: The Trace-gun violence

Hi Courtney,

The responses are fine.

Thank you,
Linda

Sent from my BlackBerry

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 12:49 AM Eastern Standard Time
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR); Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Linda,
Will you please take a look at the responses and let me know if you are ok with how they read? Deb revised but unfortunately I don't have her exact changes. Looks like mainly she shortened some answers.
Thank you!
Courtney

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both

research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why? (approved/reviewed by Division of Population Health)

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States

Prev Med. 2015 Oct;79:5-14

http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010

MMWR. August 2, 2013 / 62(30);597-602

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm
Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached
Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm
Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm
Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm
Most recent NVDRS Surveillance Summary:
Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
See edits in red below. I didn't provide an answer for the first question. I will leave that one to someone else.
Let me know if you have any questions.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 12:09 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: For Review: The Trace-gun violence

Good afternoon,
Kate Masters with The Trace has the questions below (directed towards Deb). Kate asked us several questions about Wilmington and gun violence back in November. Please edit below and also looking for guidance on Q1 & Q3.

Thanks much!
Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. There is nothing in CDC's appropriation language that prevents the agency from conducting gun violence research. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

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it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

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- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

CDC's Behavioral Risk Factor Surveillance System (BRFSS), which provides state and national data, included questions on firearm safety in the 1990s and early 2000s. The last time firearm questions were included in the BRFSS survey was 2004. The BRFSS questionnaire is designed by a working group of BRFSS state coordinators and CDC staff. While CDC coordinates the work, the actual states run the program and have the voting rights to make additions and changes to the survey questionnaire from year to year. The Injury Center submitted a formal application to include the firearm questions on the 2016 survey. The BRFSS State Coordinators did not approve the inclusion of the firearm questions (or questions pertaining to other topics) citing concerns about the length of the current survey and declining response rates in RDD surveys in general. (making sure this is still ok with DPH)

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached

Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm

Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm

Most recent NVDRS Surveillance Summary:

Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

Courtney N. Lenard, MA
Health Communication Specialist I National Center for Injury Prevention and Control I Health Communication and Science Office I O: 770.488.3733 I Monday & Friday telework: 404.808.3037

CDC 24/7
Saving Lives and Protecting People from Violence and Injury

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: 24 Aug 2016 21:03:26 +0000
To: Fox, Kate (CDC/ONDIEH/NCIPC);Patterson, Sara S. (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Ghulamali, Sabah (CDC/ONDIEH/NCIPC)
Subject: RE: Draft TPs for Next Week: Please Review by Noon on Tuesday

Thx- this works- maybe just a bit of info on what is together for girls? Ie how big, what they do, etc- I know we have VACS through them, but not familiar with the org itself

Deb Houry, MD, MPH
Director
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
4770 Buford Highway, NE; Mail Stop F63; Atlanta, GA 30341
Twitter: @DebHouryCDC
Phone: (770) 488-4696 || Fax: (770) 488-4222

From: Fox, Kate (CDC/ONDIEH/NCIPC)
Sent: Wednesday, August 24, 2016 3:02 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) ; Patterson, Sara S. (CDC/ONDIEH/NCIPC) ; Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Ghulamali, Sabah (CDC/ONDIEH/NCIPC)
Subject: RE: Draft TPs for Next Week: Please Review by Noon on Tuesday

Re: LOS: Paul Bonta decided that it wasn't worth pursuing at this point, given that they submitted a new application. He will, however, request a LOS if this application is rejected at the editorial panel meeting. Also, I've attached the last set of briefing materials. These are for the meet-and-greet with the new Executive Director of Together for Girls. We've kept these materials higher-level and are including background materials, since we expect it be an informal meeting. Let us know if you have questions or need anything else.

Thanks!

Kate

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, August 24, 2016 1:38 PM
To: Patterson, Sara S. (CDC/ONDIEH/NCIPC) <afo0@cdc.gov>; Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>
Cc: Ghulamali, Sabah (CDC/ONDIEH/NCIPC) <leu0@cdc.gov>; Fox, Kate (CDC/ONDIEH/NCIPC) <kkj4@cdc.gov>
Subject: RE: Draft TPs for Next Week: Please Review by Noon on Tuesday

On Schatz I pulled my notes from last trip

Falls- big interest of the Senator- they had been briefed by American College of Prev Med re the CPT code we have been working with them on- this CPT code was recently rejected by AMA- we will be resubmitting this month. They may be interested in sending letter of support to AMA re this (of note, HI has one of the lowest rates of falls in US- has good community based Tai Chi program)

Suicide- advocates recently met with them- I mentioned the FY17 request and what our vision for work in suicide would be (community level interventions in states and tribal communities; implementing evidence based approaches; expanding NVDRS nationally)- she said they are extremely interested in suicide and would like to support our efforts

FV- she brought this up esp with AMA resolution this week re lifting Dickey amendment. I talked about the work we were doing (child injury papers, optional BRFSS module, ICRC projects) but talked about the

importance of report language and/ or appropriation. She wants to have a follow up discussion on this to see how they can help move this forward
Did we want to ask about LOS to AMA; and was there a follow up discussion regarding FV?
Deb Houry, MD, MPH
Director
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
4770 Buford Highway, NE; Mail Stop F63; Atlanta, GA 30341
Twitter: @DebHouryCDC
Phone: (770) 488-4696 || Fax: (770) 488-4222

From: Patterson, Sara S. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, August 23, 2016 9:07 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>
Cc: Ghulamali, Sabah (CDC/ONDIEH/NCIPC) <leu0@cdc.gov>; Fox, Kate (CDC/ONDIEH/NCIPC) <kkj4@cdc.gov>
Subject: Draft TPs for Next Week: Please Review by Noon on Tuesday

Hi Deb and Amy,
Attached are the draft talking points for our two congressional briefings and the meetings with BIAA/NASHIA and AAMC next week. The one set of TPs that are outstanding are the ones you'll need for your meeting with Together for Girls on Wednesday, Deb. If you could review and send Sabah and Kate any feedback by noon on Tuesday, they can finalize and get you (Deb) a final packet on Friday before you head out. Deb, would you be OK bringing me a packet, too, when you come to DC? I could print from home on Sunday when I return (b)(6) but it may be easier to just get a packet made at work if you don't mind bringing it with you to DC.
Thanks!
Sara

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: 24 Aug 2016 17:50:47 +0000
To: Fox, Kate (CDC/ONDIEH/NCIPC);Patterson, Sara S. (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Ghulamali, Sabah (CDC/ONDIEH/NCIPC)
Subject: RE: Draft TPs for Next Week: Please Review by Noon on Tuesday

Sounds good
Deb Houry, MD, MPH
Director
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
4770 Buford Highway, NE; Mail Stop F63; Atlanta, GA 30341
Twitter: @DebHouryCDC
Phone: (770) 488-4696 || Fax: (770) 488-4222

From: Fox, Kate (CDC/ONDIEH/NCIPC)
Sent: Wednesday, August 24, 2016 1:50 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) ; Patterson, Sara S. (CDC/ONDIEH/NCIPC) ; Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Ghulamali, Sabah (CDC/ONDIEH/NCIPC)
Subject: RE: Draft TPs for Next Week: Please Review by Noon on Tuesday

I'll follow-up with Hilary to see if we followed up on the LOS.
On FV, we'd recommend focusing on NVDRS/suicide and mostly doing Q&A on FV. Based on what you discussed last time, I'm not sure there's too much more we'd have to say, other than updating her on the other papers we have in the works. Maybe we can discuss in our 2:1 tomorrow?

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, August 24, 2016 1:38 PM
To: Patterson, Sara S. (CDC/ONDIEH/NCIPC) <afo0@cdc.gov>; Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>
Cc: Ghulamali, Sabah (CDC/ONDIEH/NCIPC) <leu0@cdc.gov>; Fox, Kate (CDC/ONDIEH/NCIPC) <kkj4@cdc.gov>
Subject: RE: Draft TPs for Next Week: Please Review by Noon on Tuesday

On Schatz I pulled my notes from last trip
Falls- big interest of the Senator- they had been briefed by American College of Prev Med re the CPT code we have been working with them on- this CPT code was recently rejected by AMA- we will be resubmitting this month. They may be interested in sending letter of support to AMA re this (of note, HI has one of the lowest rates of falls in US- has good community based Tai Chi program)
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From: Patterson, Sara S. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, August 23, 2016 9:07 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>
Cc: Ghulamali, Sabah (CDC/ONDIEH/NCIPC) <leu0@cdc.gov>; Fox, Kate (CDC/ONDIEH/NCIPC) <kkj4@cdc.gov>
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Hi Deb and Amy,

Attached are the draft talking points for our two congressional briefings and the meetings with BIAA/NASHIA and AAMC next week. The one set of TPs that are outstanding are the ones you'll need for your meeting with Together for Girls on Wednesday, Deb. If you could review and send Sabah and Kate any feedback by noon on Tuesday, they can finalize and get you (Deb) a final packet on Friday before you head out. Deb, would you be OK bringing me a packet, too, when you come to DC? I could print from home on Sunday when I return (b)(6) but it may be easier to just get a packet made at work if you don't mind bringing it with you to DC.

Thanks!

Sara

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 1 Aug 2016 15:44:44 +0000
To: Sloan, Robin (CDC/ONDIEH/NCIPC) (CTR)
Subject: RE: Firearms Inquiry

You're welcome.

From: Sloan, Robin (CDC/ONDIEH/NCIPC) (CTR)
Sent: Monday, August 01, 2016 11:18 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: Firearms Inquiry

Good stuff. Thanks, Linda!

Robin Sloan, MA, CCPH | Health Communication Specialist | Carter Consulting, Inc.
CDC | NCIPC | DVP | OD | HCET

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 11:00 AM
To: Sloan, Robin (CDC/ONDIEH/NCIPC) (CTR) <dqu1@cdc.gov>
Subject: RE: Firearms Inquiry

Hi Robin,

See response below.

Response:

(b)(5)

(b)(5)

- Firearm injuries in the United States, Prev Med. 2015 Oct;79:5-14.
- Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010, MMWR. August 2, 2013 / 62(30);597-602.
- Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012, MMWR. March 6, 2015 / 64(08);201-205.
- Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010, MMWR. July 12, 2013 / 62(27);545-548.

From: Sloan, Robin (CDC/ONDIEH/NCIPC) (CTR)
Sent: Monday, August 01, 2016 9:19 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Subject: Firearms Inquiry

Hey Linda,

I think the question below is a new one. Can you help me with a response?

Subject: Information on Gun Violence and Firearm Use
From: General Public
Email Address: (b)(6)
Your Question: I am doing a study on gin violence and information that is collected for my internship. I am asking what sort of information, such as reports, data, statistics, and outcomes, were collected by the CDC before the Dickey Act was approved.

Robin G. Sloan, MA, CCPH
Health Communication Specialist | Carter Consulting, Inc.
CDC | NCIPC | DVP
770-488-4019 (office)
404-625-3272 (mobile)
Telework Tu & Fri. Please email.

CDC 24/7
Saving Lives and Protecting People from Violence and Injury

From: Sucosky, Marissa Scalia (CDC/ONDIEH/NCCDPHP)
Sent: 14 Oct 2016 16:45:51 -0400
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Cc: Doyle, Nadine (CDC/ONDIEH/NCIPC)
Subject: RE: firearms research -- please review by COB 10/14

Thank you very much, Linda!
Marissa Scalia Sucosky, MPH
Policy and Partnerships Team Detailee
DVP/NCIPC/CDC

Blackberry: 404-384-9135
msucosky@cdc.gov

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Friday, October 14, 2016 4:11 PM
To: Sucosky, Marissa Scalia (CDC/ONDIEH/NCCDPHP)
Cc: Doyle, Nadine (CDC/ONDIEH/NCIPC)
Subject: RE: firearms research -- please review by COB 10/14

Hi Marissa –
Here's the response with my suggested edits in blue. I added Steve Sumner's recent paper and the AJPM supplement on the NVDRS findings related to law enforcement, suicide, etc.
Let me know if you have any questions.
Thanks,
Linda

From: Sucosky, Marissa Scalia (CDC/ONDIEH/NCCDPHP)
Sent: Tuesday, October 11, 2016 2:05 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Cc: Doyle, Nadine (CDC/ONDIEH/NCIPC) <hvx8@cdc.gov>
Subject: FW: firearms research -- please review by COB 10/14

Hi, Linda,
In response to the inquiry we received, please review the response we have drafted and let me know whether you have anything to add or change. Also, do you have web links for the discussion papers referenced in the IOM report *Priorities for Research to Reduce the Threat of Firearm-Related Violence*:

- youth possession and acquisition of firearms
- the relationship between alcohol and firearm violence
- firearm access for persons at risk of harming themselves or others

Please respond by COB this Friday 10/14.
Marissa Scalia Sucosky, MPH
Policy and Partnerships Team Detailee
DVP/NCIPC/CDC

Blackberry: 404-384-9135
msucosky@cdc.gov

Dear Dr. Zehrung:

(b)(5)

(b)(5)

Recent examples are included below.

- Findings from the National Violent Death Reporting System - Special Supplement; *American Journal of Preventive Medicine;* 2016 Nov; http://www.ajpmonline.org/issue/S0749-3797(16)X0016-5
- Sentinel events preceding youth firearm violence: an investigation of administrative data in Delaware. *American Journal of Preventive Medicine;* 2016 Nov; 647-655. http://www.ajpmonline.org/article/S0749-3797(16)30307-5/fulltext
- Firearm injuries in the United States. *Preventive Medicine.* 2015 Oct;79:5-14; http://www.ncbi.nlm.nih.gov/pubmed/26116133
- Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006-2007 and 2009-2010
  MMWR. August 2, 2013 / 62(30);597-602;

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Additionally, in response to the President's *Now is the Time* plan released in January of 2013, CDC asked the Institute of Medicine (IOM) in collaboration with the National Research Council (NRC) to convene a committee to engage diverse stakeholders and identify the most pressing research questions on gun violence, including those with the greatest potential public health impact. The IOM/NRC released their report *Priorities for Research to Reduce the Threat of Firearm-Related Violence*on June 5, 2013. (Note that if you wanted to download a PDF, you just need to create a free guest account on the IOM page.)

The CDC Foundation, in collaboration with the CDC, also commissioned the IOM/NRC to develop and disseminate three supplemental discussion papers focusing on priorities identified in 2013 report: youth possession and acquisition of firearms; the relationship between alcohol and firearm violence; and firearm access for persons at risk of harming themselves or others.
Direct Links to the Papers:
http://iom.nationalacademies.org/~/media/Files/Activity%20Files/Global/2014-DEC-18/Alcohol-Firearms.pdf.
http://nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Youth-Acquisition-Carrying-Firearms-US.pdf
http://iom.nationalacademies.org/~/media/Files/Activity%20Files/Global/2014-DEC-18/Firearms-Suicide-Homicide.pdf.
The Injury Center Funding Opportunity Announcements (FOAs) Web page lists funding opportunities that have been recently available in our Center. You might also be interested in the CDC Injury Center Research Priorities (scroll to the bottom of the webpage for direct links to Violence Prevention research topics).
I hope this addresses your questions. Please let me know if you need additional information.

From: David Zehrung [mailto (b)(6)
Sent: Monday, September 19, 2016 5:06 PM
To: Sucosky, Marissa Scalia (CDC/ONDIEH/NCCDPHP) <aql8@cdc.gov>
Subject: Fwd: firearms research

Hi Marissa, DVP Inquiries suggested I reach out to you.
As President-Elect of the Pennsylvania Psychological Association, I am working on an issue that has arisen. Some of our members, in advocating for more gun control, have suggested that CDC is prohibited from conducting firearms related research. I contacted the CDC info folks, who provided the helpful statement at the bottom of this email.
I'd be interested in understanding in greater detail about funding/research directions over the next year or so, as well as initiatives CDC has in place currently that might relate to firearms and violence and/or suicide. As an association, we are not interested in taking a stand on policy issues such as gun control, but we are interested in violence prevention efforts.
This must sound rather vague. I guess two main lines of questions I have relate to a) things we can share with our membership that CDC is doing on these topics; b) possibly grants that might be available for PA to conduct research in this area.
Regards,
David

David L. Zehrung, Ph.D.
Greencastle, PA
(b)(6)
(b)(6)

Begin forwarded message:
From: "DVP Inquiries (CDC)" <dvpinquiries@cdc.gov>
Subject: RE: firearms research
Date: September 19, 2016 at 12:48:06 PM EDT
To: (b)(6) (b)(6) >
Thank you for your inquiry.

One of our Subject Matter Experts from CDC's Policy Team will be in contact with you by next week. In the meantime, please direct your questions to Marissa Scalia Sucosky at msucosky@cdc.gov.

From: David Zehrung (b)(6)
Sent: Friday, September 16, 2016 2:50 PM
To: DVP Inquiries (CDC)
Subject: Re: firearms research

Thank you for your prompt and informative reply!
I am President-Elect of the Pennsylvania Psychological Association, and we are expanding our work on interpersonal violence, and suicide prevention. Is there a person at CDC I might speak with/correspond with further regarding firearms research, the budget regarding this, etc?
Much appreciated,
David

(b)(6)

David L. Zehrung, Ph.D.
Greencastle, PA
(b)(6)

On Sep 16, 2016, at 2:02 PM, DVP Inquiries (CDC) <dvpinquiries@cdc.gov> wrote:

Thank you for contacting the Centers for Disease Control and Prevention.

CDC appropriation language states that none of the funds made available to CDC may be used, in whole or in part, to advocate or promote gun control (in place since FY1997; extended to all of HHS in 2012), but the language does not prohibit the CDC from conducting public health research into gun violence. CDC historically conducted research on firearm-related violence, and in 2013, the President called upon the CDC and other scientific agencies to conduct research into the causes and prevention of gun violence. The CDC and the Obama Administration are committed to engaging in this work, and many partners and several members of Congress are interested in CDC doing research on this topic. That said, CDC has very limited discretionary funding to conduct this research and would need the funding requested in the FY2017 President's Budget to conduct significant research in this area.

From: Eiring, Hilary (CDC/ONDIEH/NCIPC)
Sent: 21 Jun 2018 09:02:38 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Cc: Watkins, Jacqueline (CDC/OID/NCEZID);Nesbit, Brandon (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: OD TPs for NAM meeting
Attachments: Epi_SAHS_ForensicSciInternational.docx, Trends in SAVD 1992-2016 v3.pptx, FACT SHEET_Vital Signs_June_2018_Suicide_Final_WEB.PDF, MMWR_Vital Signs_ Suicide_6.7.2018_article.pdf, Kegler FA Homicides and Suicides Metro Areas (Manuscript).docx, Redfield NAM Meeting NCIPC 6 20 2018 v2.docx

Thanks. Updates attached. I confirmed with Liz Finkelman from NAM that she did call in to the BSC since she reached out about the slides and minutes.
I also have attached the supplemental materials so that it's all in one place to go back to Hugh. I am confirming anticipated publication date for the MMWR – will send that to Jackie once I have it.
Thanks,
Hilary

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 9:13 PM
To: Eiring, Hilary (CDC/ONDIEH/NCIPC)
Cc: Watkins, Jacqueline (CDC/OID/NCEZID) ; Nesbit, Brandon (CDC/ONDIEH/NCIPC) ; Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: OD TPs for NAM meeting

I had a bunch of suggested edits- I also think there needs to be a BLUF for both of our sections and an ask where appropriate

---

From: Eiring, Hilary (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 3:01 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>
Cc: Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>; Nesbit, Brandon (CDC/ONDIEH/NCIPC) <vxw6@cdc.gov>
Subject: For Review: OD TPs for NAM meeting

Hi Deb,
We put together background information and talking points for Dr. Redfield's meeting with NAM. I am still waiting for the MSA paper from DVP but wanted to go ahead and get this to you before we send on to the OD (which will include the SAVD and Suicide Vital Signs) as well.
I included information from Althea on the Mental Health Forum since the request did not go to her directly.
Please let me know if you have any questions/edits/concerns.
Thanks,
Hilary

From: Eiring, Hilary (CDC/ONDIEH/NCIPC)
Sent: Friday, June 15, 2018 2:03 PM
To: Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>
Subject: Re: OD TPs for NAM meeting

Yes, we can handle and I'll let you know if I have any questions.
Thanks!

From: Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>
Date: June 15, 2018 at 1:57:28 PM EDT
To: Eiring, Hilary (CDC/ONDIEH/NCIPC) <vte0@cdc.gov>
Subject: OD TPs for NAM meeting

Hilary,

Dr. Redfield is meeting with NAM on June 26th and we've been asked to provide information to CDC OD by June 20th at 12noon. The agenda for the NAM meeting includes the following:

1. Vital Directions for Health and Health Care initiative (see attached checklist)
2. Action Collaborative on countering the opioid epidemic (see attached concept paper)
3. Potential research on GV

For #2, OD is requesting any pertinent background or messages around the action collaborative. Deb noted that she and Anne are CDC reps to the action collaborative and we have funded it (Deb thinks $10k/yr for 2 years). Deb suggested we mention that Liz F from NAM called into our BSC meeting on benchmarking and has been communicating with Deb about our project and how hopefully it can help inform the consensus paper they are working on scheduled to come out in about 20 months. Either Anne or Deb will attend a kick off on July 27th. Deb also mentioned, there is a mental health forum Anne is funding for $50k and Althea is the rep (I don't know who that is, but assume you do – let me know if we need to figure out though).

For #3, they asked for our standard GV talking points. Deb asked we include the MSA and SAVD in clearance (Elizabeth was tracking down the SAVD article the other day and should have it; do you know anything about the MSA?) to highlight that we are still continuing to produce GV surveillance papers and we will now be expanding our NVDRS to al. 50 states. Deb suggested that we share the suicide vital signs. Also asked to mention we don't have a dedicated line and that if we get an appropriation for for GV we would use the NAM research agenda to guide our funding announcements (especially around surveillance, safe storage, kids and vets).

Can you / your team take the lead on this?

Jackie

The Epidemiology of School-Associated Homicide-Suicides in the United States, 1994-2014

Ruth W. Leemis, MPH,[a] Kristin. M. Holland, PhD,[a] Elizabeth M. Gaylor, MPH,[1] Kameron Sheats, PhD,[a] Jeffrey E. Hall, PhD,[b] and Linda L. Johnson[c]

[a]Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 4770 Buford Highway NE, MS F-64, Atlanta, GA, USA 30341

[b]Office of Minority Health and Health Equity, Centers for Disease Control and Prevention; 4770 Buford Hwy Mail Stop K-77, Atlanta, GA, USA 30341

[c]Karna, LLC; 4770 Buford Highway NE, MS F-64, Atlanta, GA, USA 30341

Correspondence should be directed to: Ruth W. Leemis, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Highway NE, MS F-64, Atlanta, GA, USA 30341. Telephone: 770-488-0681. Fax: 404-471-8603. Email: RLeemis@cdc.gov

Declarations of interest: None

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Disclaimer: The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Acknowledgements

The authors would like to thank Dr. Susan M. Sutton Clawson for her contributions to data collection and electronic data entry. Dr. Sutton Clawson was affiliated with the Division of Violence Prevention at the National Center for Injury Prevention and Control within the Centers for Disease Control and Prevention at the time of study collaboration and was compensated as an ORISE Fellow by the Department of Justice. She now works at the United States Department of Health and Human Services, Office of the Secretary.

The Epidemiology of School-Associated Homicide-Suicides in the United States, 1994-2014

Abstract

School-associated homicide-suicides are tragic events that devastate the communities where they occur and even the nation at large. However, little is known about such events and how to prevent them. This study used the School-Associated Violent Death Surveillance System, a population-based epidemiological study, to assess national frequencies of school-associated homicide-suicides from July 1, 1994 through June 30, 2014 as well as event and decedent characteristics. Data were obtained from law enforcement investigative reports, structured telephone interviews with law enforcement officials, and media scans. Over 20 years, 42 (0-6 annually) school-associated homicide-suicide events resulted in 141 deaths: 98 homicides and 43 suicides. Six cases (14%) were mass killings. All 141 deaths (100.0%) involved firearms. Homicide victims were often female (n=59, 69%), non-Hispanic White (n=58, 67%), students (n=50, 58%) or faculty/staff (n=24, 28%). Suicide decedents were mostly male (n=41, 95%), non-Hispanic White (n=25, 58%), community residents (n=16, 37%), students (n=11, 26%), or staff partners (n=9, 21%). Most events (n=27, 64%) involved intimate partner violence. Although school-associated homicide-suicides are rare, they involve a complex mix of interpersonal dynamics that are not often tied to conditions within schools themselves. Epidemiologic examinations of these events can help to inform prevention efforts.

Highlights

Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). You can view example Highlights on our information site. https://www.elsevier.com/authors/journal-authors/highlights

Keywords

violence; schools; epidemiology; homicide-suicide; intimate partner violence

Introduction

While homicide(s)-followed-by-suicide(s) are relatively rare in the U.S., approximately 1,500 Americans, about 13% of whom are children, die in homicide-suicide events annually [1-3]. By definition, these events involve multiple deaths and can have detrimental effects on the communities in which they occur and even the nation at large, as some events are highly publicized [4]. Yet, little epidemiological research on homicide-suicide exists, and most studies focus on localized or international samples, or are limited by brief time periods for which data are available [5-9].

Studies assessing contextual factors of homicide-suicides have demonstrated that they are usually perpetrated by adult men, typically result in adult female or child homicide victims, and are often precipitated by interpersonal or intimate partner violence [1-3,5,7-10]. Additionally, incidents are commonly perpetrated in private settings, such as the home [2,11]. While the rates of homicide-suicide events vary by study locale and time period, these characteristics of perpetrators, victims, and their relationships have been consistently reported across studies. However, there may be reason to believe that the demographic and relational characteristics of homicide-suicide events in school settings, in particular, differ from those perpetrated in private settings. For instance, case studies of mass shootings at schools indicate that both the victims and perpetrators of these events are often school-aged, and the perpetrator is frequently a classmate of the homicide victims; ostracism and teasing by fellow students are frequently noted as motivations for these events [12]. However, there is also evidence of exceptions to these commonalities, specifically where the perpetrator of a school shooting is identified as an adult who was unknown to homicide victims [13,14]. While these studies are helpful for understanding relationship distinctions common to school shootings, their focus on mass shootings provides little to no information on violent deaths that occur in school settings but that result in a small number of victims or events that involve only family members and victims related to the perpetrator. Additionally, they provide little demographic information regarding the victims and perpetrators.

The School-Associated Violent Death Surveillance System (SAVD-SS) collects data on homicide, suicide, and legal intervention deaths and allows for analysis of all reported homicide-suicide events occurring in and around U.S. primary and secondary schools. Previous studies using SAVD-SS data have examined context and trends related to school-associated homicides and suicides. For example, from 1994 to 1999, there were 220 school-associated violent death (SAVD) events, 78% (n=172) of which were homicides, 13% (n=30) were suicides, and 5% (n=11) were homicide-suicides. The average annual rate of SAVDs during this period was very low – less than 1 per 100,000 students [15]. SAVD-SS data have demonstrated that SAVDs remain rare events over time, and homicide-suicide events in the school setting are even rarer. To date, however, no SAVD-SS studies have closely examined homicide-suicide events in school settings, other than by count [15], nor have they assessed decedent relationships and school affiliations in detail. The objective of the current study is to provide an epidemiologic characterization of school-associated homicide-suicides that occurred at elementary and secondary schools in the U.S. over a 20-year period, along with the demographic and relational characteristics of all victims and perpetrators involved.

Material and Methods

The SAVD-SS was initiated in 1992 by the Centers for Disease Control and Prevention (CDC), in collaboration with the Departments of Education and Justice, as an epidemiological study to describe the distribution of SAVDs and identify common features of these deaths. The SAVD-SS includes descriptive data on violent deaths where a) the fatal injury occurred on the campus of a functioning elementary or secondary school in the U.S., b) while the victim was on the way to/from regular sessions at such a school, or c) while the victim was attending or traveling to/from a school-sponsored event. Information on violent deaths on university campuses are not included within the surveillance system due to difficulties in identifying school boundaries and fewer policies about where students and staff are supposed to be. SAVD-SS cases include the deaths of students and non-students (e.g., faculty/staff,

family members, community residents), and were identified through a systematic search of media databases via Nexis and then confirmed through interviews with law enforcement (LE) officers familiar with each event. Data were obtained from LE investigative reports and structured telephone interviews with LE officials on an ongoing basis as part of the surveillance system's protocol. The U.S. Office of Management and Budget and CDC's Institutional Review Board approved data collection activities, and data are protected with an Assurance of Confidentiality. As a result, detailed information about the specific locations and characteristics of these events cannot be disclosed.

For this study, we examined the frequency and characteristics of homicide-suicide events from July 1994–June 2014 when at least one of the homicide or suicide deaths was school-associated.[1] Data collection tools were designed to gather information on SAVDs and any affiliated perpetrators, so data are available for school-associated homicides and suicides and off-campus suicides when decedents were also school-associated homicide perpetrators. Homicide deaths that occurred off-campus but were affiliated with the homicide-suicide event are noted within the system, but detailed demographic information for those victims is not collected. Thus, if a homicide victim is killed off-campus prior to an SAVD, information about the off-campus homicide victim may be limited.

Of the 914 SAVDs captured by SAVD-SS from 1994–2014, 42 school-associated homicide-suicides were identified. Supplemental Nexis scans were conducted to identify case characteristics when LE interviews or reports were not received (n=1) or lacked contextual information (n=1). These scans used similar methods as a seminal study to identify decedent relationships and school affiliation [16], which were otherwise missing. Specifically, Nexis search terms included relevant victim and school names; articles published within two years of the incident were coded for pertinent information.

Data extraction forms were created in EpiInfo 3.5.4, which six researchers used to enter data from LE reports (n=39), LE interviews (n=18), and supplementary Nexis scans (n=2). Two researchers conducted quality assurance reviews and cleaned the data. Finally, the frequency and nature of school-

[1] Due to a lack of complete data for cases from Fall 1992 through Spring 1994, those years were not included in this study.

associated homicide-suicides were examined in SPSS v.23 using descriptive statistics. Attributes of interest included frequency of events, decedent demographics, relational characteristics, and school affiliation. Supplemental media scan and data extraction procedures as well as analyses were conducted in 2016 and 2017.

Results

Overall, 42 school-associated homicide-suicides occurred in and around U.S. schools from 1994–2014. Of those events, 34 (81%) involved one homicide decedent and one suicide decedent. Eight cases (19%) involved multiple homicide decedents, six (14%) of which were mass killings (i.e., killings with three or more homicide victims) [17]. One of those eight cases also had multiple suicide decedents. The 42 school-associated homicide-suicides resulted in 141 deaths: 120 (85.1%) that were school-associated and 21 (14.9%) that occurred off campus prior or subsequent to a SAVD. Table 1 presents the number of deaths by homicide and suicide and according to school-association case criteria; average death counts for events and mass killings are also reported. All 141 deaths (100%) involved firearms.

Table 1. Number of Deaths in 42 Homicide-Suicide Events, United States, 1994-2014

	On-campus Deaths (n=120)	**Off-campus Deaths (n=21)**	**Total Deaths (N=141)**
	No. (%)	**No. (%)**	**No. (%)**
Homicide	86 (72)	12 (57)	98 (70)[b]
Suicide	34 (28)	9 (43)	43 (31)[b]
	Average (Range)	**Average (Range)**	**Average (Range)**
Deaths per Event (n=42 events)	2.9 (1 - 27)	0.5 (0 - 2)	3.4 (2 - 28)
Deaths per Event Excluding Mass Killings[a] (n=36 events)	1.6 (1 - 3)	0.4 (0 - 2)	2.1 (2 - 3)[c]
Deaths per Mass Killing[a] (n=6 events)	10.3 (2 - 27)	0.8 (0 - 2)	11.2 (4 - 28)[c]

[a]Mass killings include cases where there are three or more homicide victims.
[b]Percentages within categories may not sum to 100% due to rounding.
[c]Averages for on-campus and off-campus death categories may not sum to equal the total death value due to rounding. Ranges are calculated across each individual event and cannot be summed across categories.

Decedent demographic characteristics and school affiliation are presented in Table 2. Homicide victims had a median age of 16.0 years (range 7 months-73), and were often female (n=59, 69%), non-Hispanic White (n=58, 67%), students (n=50, 58%), or faculty/staff (n=24, 28%). Suicide decedents had a median age of 30.0 years (range 12-76), and were mostly male (n=41, 95%), non-Hispanic White (n=25, 58%), and either community residents (n=16, 37%), students (n=11, 26%), or staff partners (n=9, 21%). Ten cases (24%) involved 44 hospitalizations for non-fatal injuries, with a median of 1.5 per case (range 1-24). Most non-fatal injuries (n=37, 84%) occurred during mass killings. Four additional events (10%) involved students who may have intended to kill multiple people, according to information gathered by LE officers (e.g., suicide decedent disclosed intent to kill many people), but did not succeed.

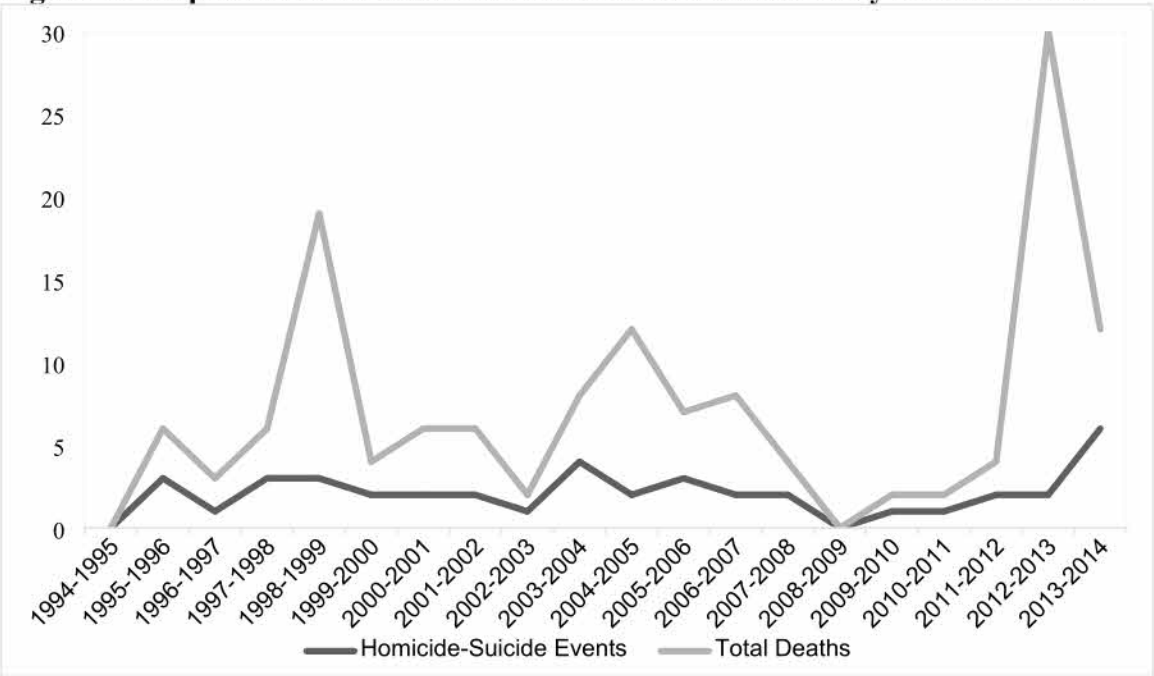
Table 2. Homicide-Suicide Decedent Demographics, United States, 1994-2014

	On-campus Homicide Victims (n=86)[a]	**Total Suicide Decedents (n=43)**
	Median (Range)	**Median (Range)**
Age	16.0 (7 months - 73)	30.0 (12 – 76)
Sex	**No. (%)**	**No. (%)**
Male	27 (31)	41 (95)
Female	59 (69)	2 (5)
Race		
White, non-Hispanic	58 (67)	25 (58)
Black, non-Hispanic	7 (8)	7 (16)
Hispanic	10 (12)	7 (16)
American Indian or Alaska Native	5 (6)	1 (2)
Asian	1 (1)	1 (2)
Unknown	5 (6)	2 (5)
School Affiliation		
Community Resident	5 (6)	16 (37)
Faculty/Staff	24 (28)	1 (2)
Student	50 (58)	11 (26)
Partner of Staff	0 (0)	9 (21)
Family Member of Student	4 (5)	4 (9)
No or Unknown School Affiliation	3 (4)	2 (5)

[a]Off-campus homicide deaths that are affiliated with the homicide-suicide event are noted within the School-Associated Violent Death Surveillance System but detailed demographic and contextual information for those homicide victims are not collected.
[b]Percentages within categories may not sum to 100% due to rounding.

Figure 1 depicts the frequencies of school-associated homicide-suicides and deaths by academic year. Zero to six school-associated homicide-suicides occurred per year, and this number fluctuated over time. Death counts varied according to the number of events but spiked in years with mass killings. The four mass killings that caused the highest spikes involved perpetrators who targeted many individuals within schools; the other two were family disputes that occurred on school property but had no known school connection. Most school-associated homicide-suicides occurred before classes began (n=14, 33%), while school was in session (n=14, 33%), or immediately after school or school-sponsored activities (n=6, 14%). Events occurred mostly in public schools (n=36, 86%). While some events involved deaths in multiple locations, incidents most frequently occurred in parking lots or school driveways (n=16, 38%), campus lawns or outdoor walkways (n=7, 17%), and hallways (n=6, 14%). Events occurred in 24 states, with nine states experiencing two or more school-associated homicide-suicides.

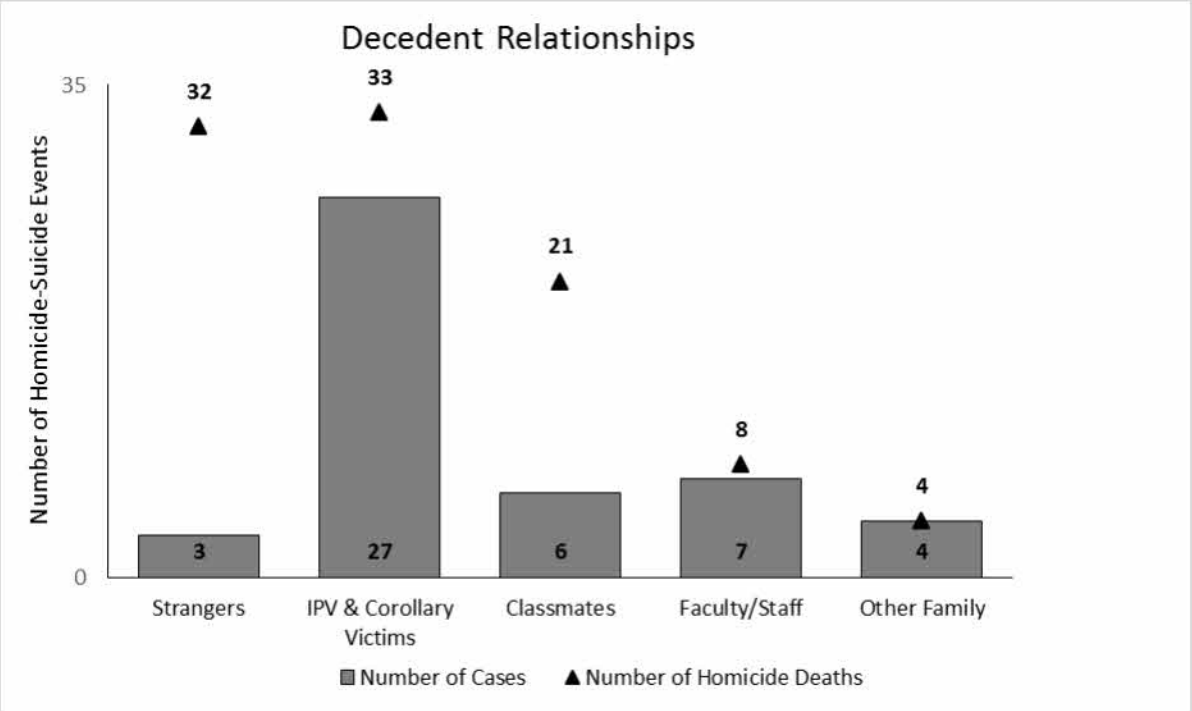
Figure 1. Frequencies of Homicide-Suicide Events and Deaths by Academic Year



Relationships between victims and perpetrators and their school affiliations varied across events. Most cases involved interpersonal or familial disputes between two (n=29, 69%) or more individuals

(n=4, 10%). Figure 2 highlights the nature of relationships between the 43 homicide perpetrators/suicide decedents and the 98 homicide victims. Most school-associated homicide-suicides (n=27, 64%) involved intimate partner violence (IPV) and/or IPV corollary victims (i.e., victims whose deaths were connected to IPV but who were not the perpetrator's intimate partner; e.g., affair partners) [18]. IPV-related events resulted in one-third of the 98 homicide deaths (n=33, 34%). Four events (10%) involved four deaths of non-student family members. With respect to school-affiliated homicide victims, seven cases (17%) involved students or teachers targeting other school faculty/staff, resulting in a total of eight deaths. Six events (14%) involved students targeting classmates resulting in 21 homicide deaths. Finally, only three cases (7%) involved strangers targeting strangers, but these events resulted in the most homicides (n=32, 33%).

Figure 2. Relationship[a] Affiliation between Homicide Perpetrators/Suicide Decedents and Homicide Victims

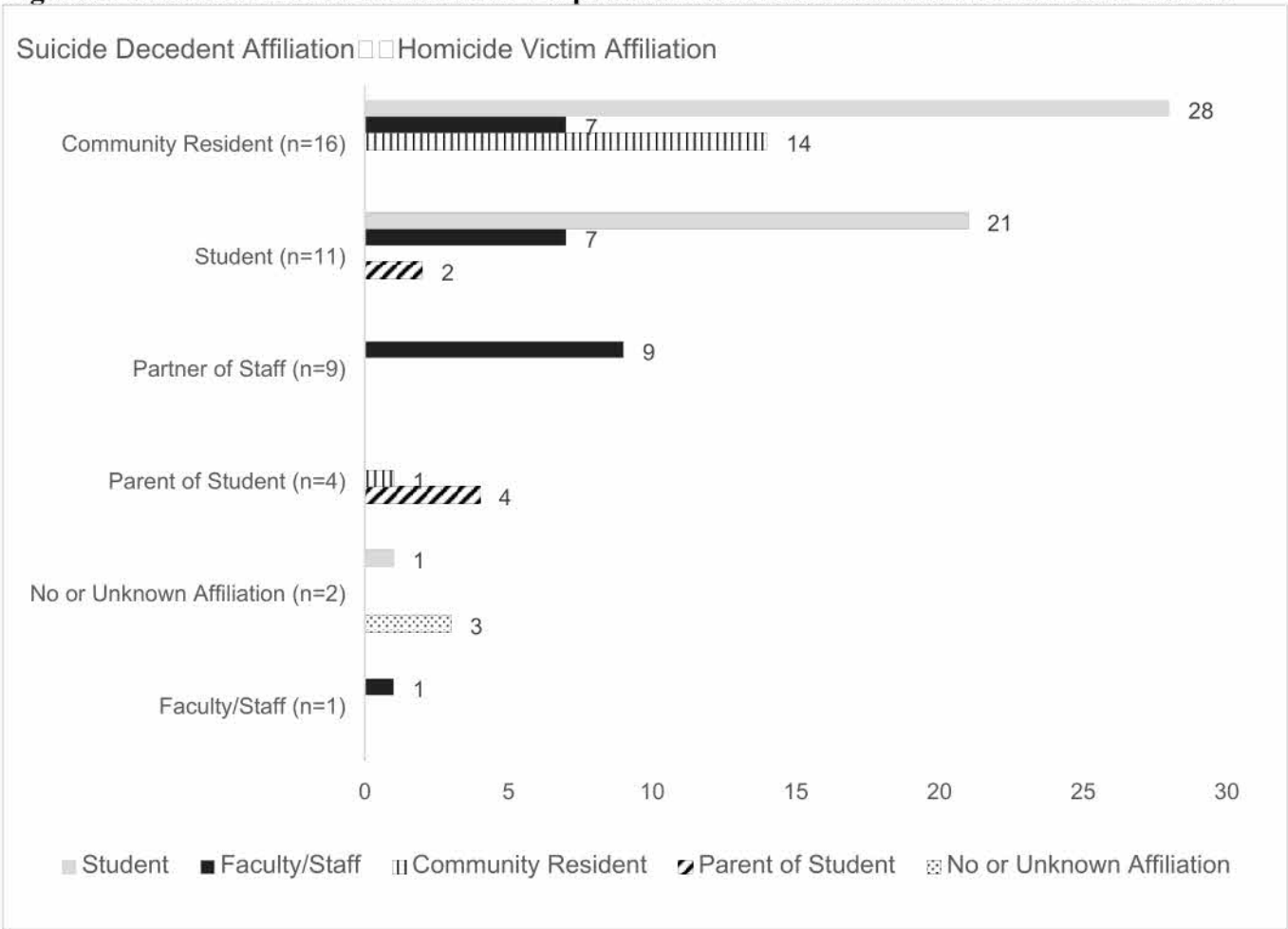


[a]Cases with more than one homicide victim may involve more than one relationship category.

Figure 3 further delineates victim-perpetrator relationships according to decedents' school affiliation. The *y*-axis of the bar chart indicates suicide decedents' school affiliation and the *x*-axis

represents the number of homicide victims by school affiliation. Twenty-five of the 43 suicide decedents (58%) had a direct school affiliation. Among school-affiliated decedents, 12 (28%) were students or faculty/staff, 9 (21%) were staff partners, and 4 (9%) were parents of students. Sixteen (37%) suicide decedents were community residents, and two (5%) suicide decedents had no or an unknown affiliation with the school. Students represented 50 homicide deaths (51%) across ten events, and were killed by community residents, other students, and one person with unknown school affiliation. Twenty-four faculty/staff members (24% of homicide deaths) were killed in 19 events by their partners, community residents, students, and another staff member. Community residents with no school affiliation were killed in twelve events by other community residents and a student's parent and accounted for 15% of homicide deaths.

Figure 3. School Affiliation of Homicide Perpetrators/Suicide Decedents and Homicide Victims



[1]Cases with more than one homicide victim may involve more than one relationship category.

Discussion

School-associated student homicides represent less than 1% of all youth homicides in the U.S. [19]; by extension, homicide-suicide events that occur at school are also very rare. Our findings indicate that over the 20 years included in this study, there were four or fewer school-associated homicide-suicides per year with the exception of 2013-2014, when six events occurred. The majority of cases involved interpersonal or family-related disputes, reinforcing evidence that school properties may serve as an opportunistic venue for targeted interpersonal violence [20,21]. This finding, coupled with the occurrence of six mass killings, is a testament to the relatively infrequent occurrence of multiple-homicide victim events [4,13,19-22]. However, four mass killings resulted in large numbers of deaths and injuries, primarily of students, due to the homicidal actions of students and strangers. The number of homicide victims is likely related to the lethality of firearms. Further, some perpetrators may have tried, but failed, to carry out multiple-victim homicides according to information gathered during LE investigations. Therefore, despite the rarity of these events, the tragic occurrence of multiple deaths per event warrants continued surveillance, research, and prevention efforts.

School-associated homicide victims in this study were often young, White, females. These results converge with findings that homicide victims in homicide-suicide events outside of school settings are often adult White females [1,2,23,24], but differed from single-victim homicides which disproportionately result in young, Black male victims [25,26]. Further, suicide decedents were slightly older than homicide victims, and often White males, which is relatively consistent with statistics for both suicide decedents and homicide perpetrators who die by suicide [2,25,27]. However, this demographic differs from homicide perpetrators who do not die by suicide, which generally have higher rates among Black males [28]. While faculty/staff, community residents, staff partners, and parents were killed in many of the events included in this study, the school environment in which these violent acts

take place is undoubtedly related to the greater frequency of student deaths compared to homicide-suicides outside of school settings.

From 1994 to 2014, most school-associated homicide-suicides involved IPV and/or IPV corollary victims, resulting in about one-third of homicide deaths. This finding is consistent with other studies, which have found that most homicide-suicides involve male perpetrators killing their female partners, often coinciding with problems of divorce/break-up and infidelity [2,3,10,24,29]. In fact, one of the most striking study findings is the involvement of so many non-students in school-associated homicide-suicides. While the majority of homicide perpetrators/suicide decedents had a direct school affiliation, less than one-third were students or faculty/staff; other school affiliations among this subgroup included staff partners or student family members. Moreover, more than one-third of perpetrators were nearby community residents with only an indirect school affiliation by proximity. Students represented the majority of homicide deaths across almost one-fourth of the cases, but faculty/staff, community residents, and student family members also played a large role in the occurrence and death tolls of these events. This is reinforced by the fact that almost three-fourths of events involved IPV- or family-related issues, and that two of the mass killings involved family disputes. Because previous school-associated violence studies have focused largely on student and faculty/staff deaths [15,19], this finding is important and warrants more contextual research.

Although there is some understanding of the circumstances preceding homicide-suicide events outside of school settings, more research is needed on circumstances preceding school-associated events. Situational factors for non-students (e.g., intimate partner problems) may be vastly different than those relevant to students, and data on the frequency of their occurrence and the characteristics of suicide decedents and homicide perpetrators may provide valuable information to guide prevention [24]. While mass killings targeting students and teachers within schools are widely publicized, this study illustrates that isolated interpersonal events between students, school staff, parents, and community residents

resulted in more overall deaths (n=72, 51%) than did the four mass killings targeting students and teachers (n=59, 42%). Thus, interpersonal violence prevention efforts are critical. Studying contextual factors may also provide insight as to whether events are motivated by homicidal anger or a planned suicide, or are a distinct act of violence [30,31].

The diversity of the individuals involved in school-associated homicide-suicides and the relationships between decedents suggests that prevention efforts should not only target students, but also school staff, parents, and community members. Comprehensive community-based strategies that aim to prevent youth violence, IPV, and suicide may also help to prevent homicide-suicides. For example, strategies that enhance school and community connectedness and access to mental health care, along with promotion of family environments that support healthy development may help ensure that the risk for suicide and perpetration of severe interpersonal violence never develops in the first place. The CDC's technical packages for violence prevention can serve as guidance for states and communities interested in implementing evidence-based programs and policies that have demonstrated impact on reducing interpersonal and self-directed violence [32]. Evidence-based programs for communities and schools include the *Pre-marital Relationship Enhancement Program (PREP)* and *Strengthening Families 10-14* which promote healthy relationships and family environments as well as the *Good Behavior Game* which has been shown to improve youth coping and problem-solving skills [33,34,35].

The results of this study should be considered in the context of several limitations. First, SAVD cases are identified primarily through media scans; thus, unpublicized events may be excluded from analyses. Second, results are based on second-hand accounts of the event through LE investigations. Relevant factors, such as information on prior IPV or suicidal ideation, may be unknown or unreported, resulting in missing information. However, this is a general limitation of postmortem interview methodology given the nature of these deaths [36]. Third, information for two cases was abstracted from Nexis media scans. Although media articles were used only to identify relationships and school

affiliations, the articles could have contained incorrect information. Fourth, because the SAVD-SS captures information on deaths but not non-lethal violence (unless it also involved a death), information is not known about homicide-suicide attempts that did not result in fatalities. Finally, despite the long period of assessment, findings are drawn from a relatively small number of cases and may change as new cases occur.

Conclusions

Despite study limitations, findings reinforce the rarity of school-associated homicide-suicides in the U.S. and provide information on the characteristics of decedents. This study builds upon previous research and provides important information about individuals with no or indirect ties to the school [15,19]. Although students and faculty/staff were the most frequent homicide victims, community residents were also commonly targeted. And, despite the large number of student homicides, faculty/staff, parents, and community residents were killed in a greater number of isolated interpersonal events, often involving IPV. In comparison, only three cases over 20 years involved strangers targeting strangers, although these events resulted in the largest number of homicide deaths. Overall, almost two-thirds of suicide decedents were affiliated with the school, whereas one-third were nearby community residents. By describing these relationships, this study highlights the complexity of school-associated homicide-suicides and the need for implementation of comprehensive prevention strategies in schools, homes, and communities at large.

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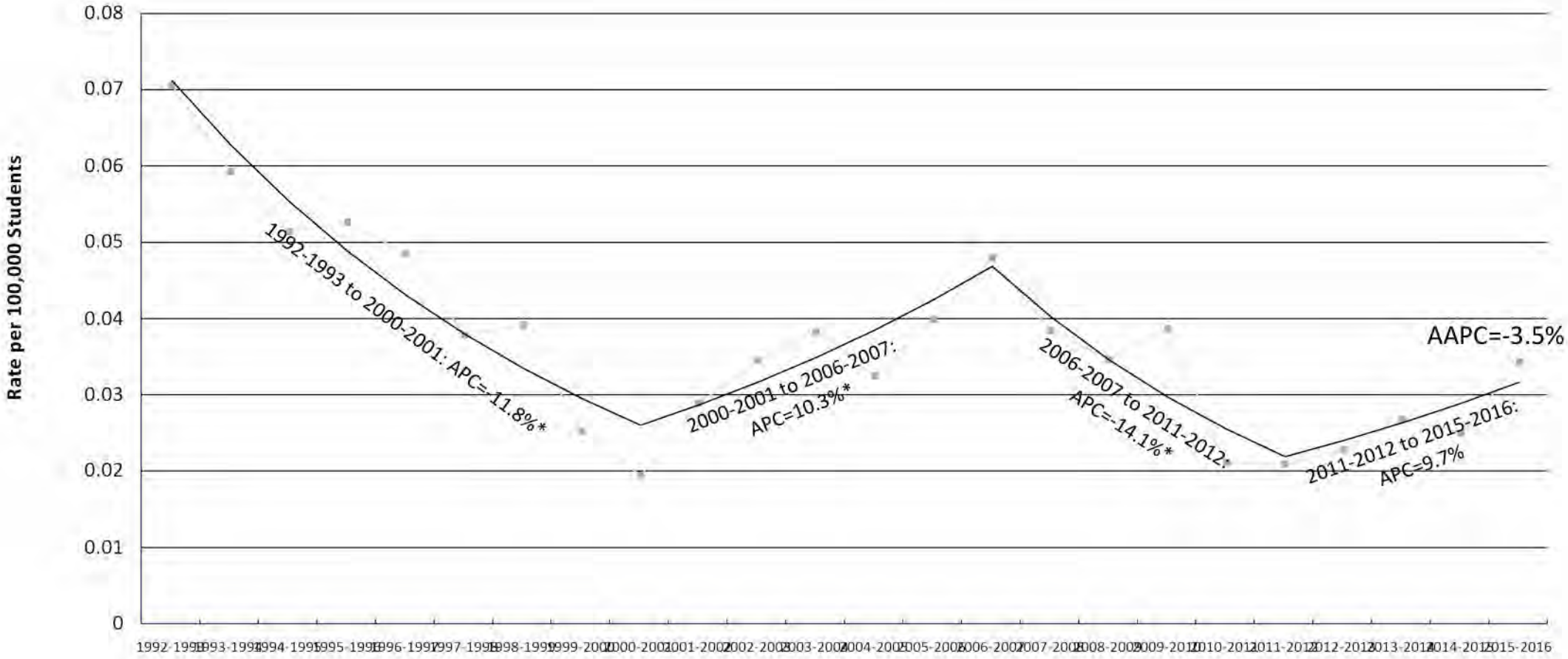
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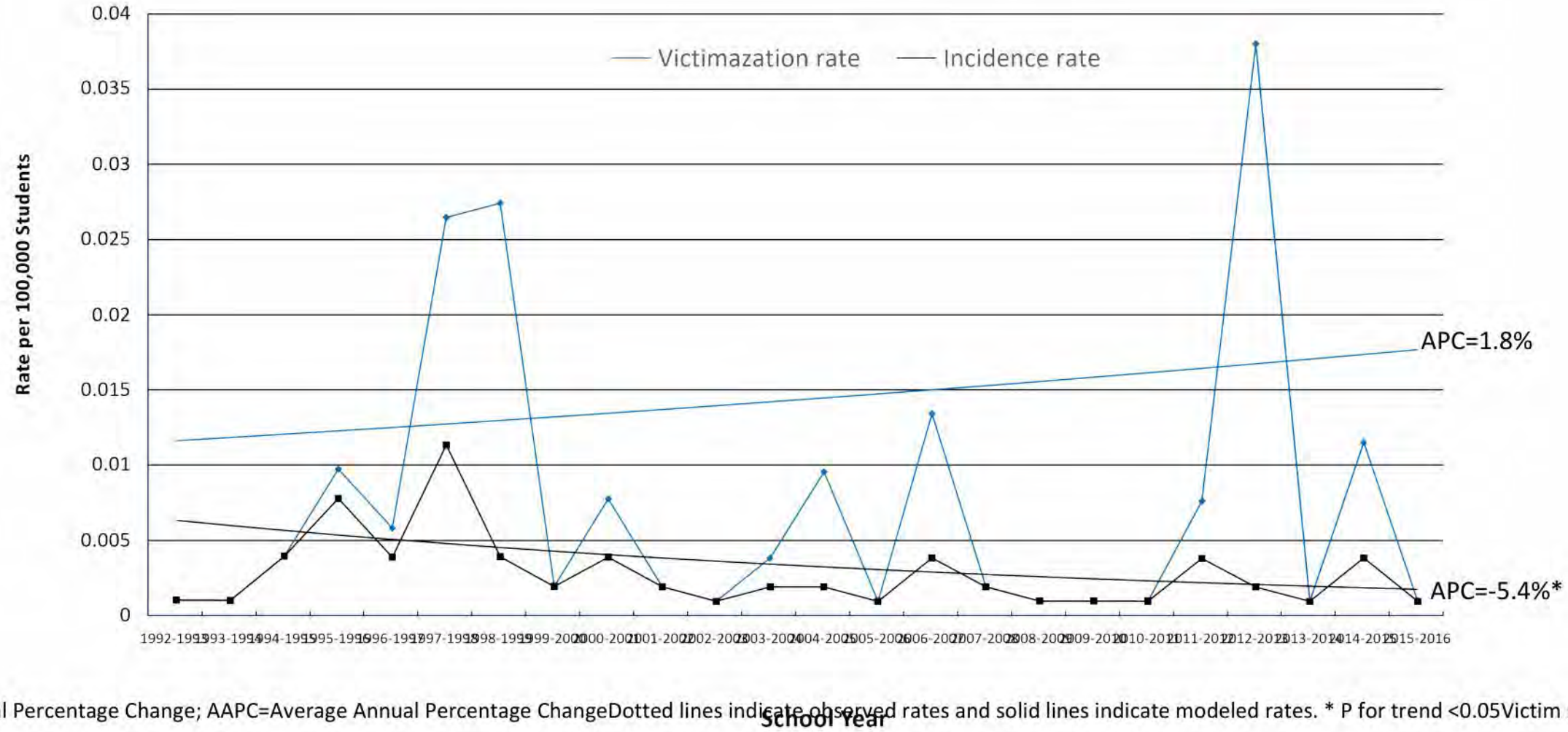
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Figure 1a. Rates of School Associated Homicide per 100,000 Students –single victim



APC=Annual Percentage Change; AAPC=Average Annual Percentage ChangeDotted lines indicate observed rates and solid lines indicate modeled rates. * P for trend <0.05Victim rates were calculat

Figure 1b. Rates of School Associated Homicide per 100,000 Students –multiple victims



APC=Annual Percentage Change; AAPC=Average Annual Percentage ChangeDotted lines indicate observed rates and solid lines indicate modeled rates. * P for trend <0.05Victim rates were calculat

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Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



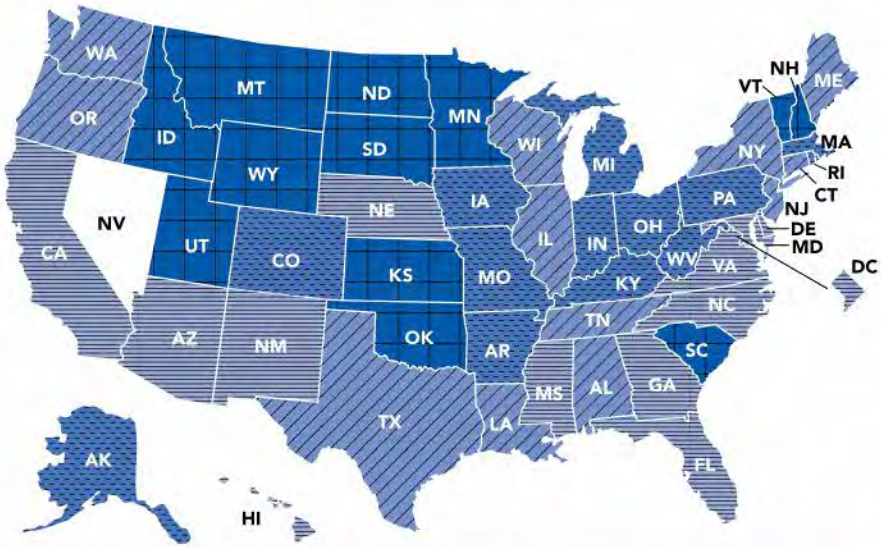
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

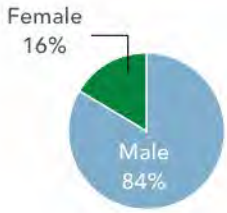


Differences exist among those with and without mental health conditions.

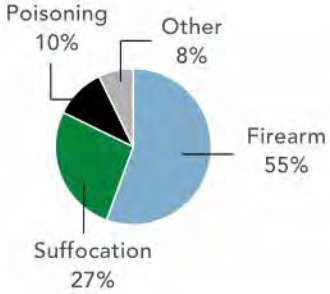
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

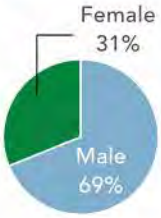


Method

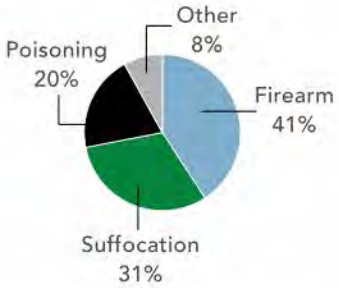


Known mental health conditions

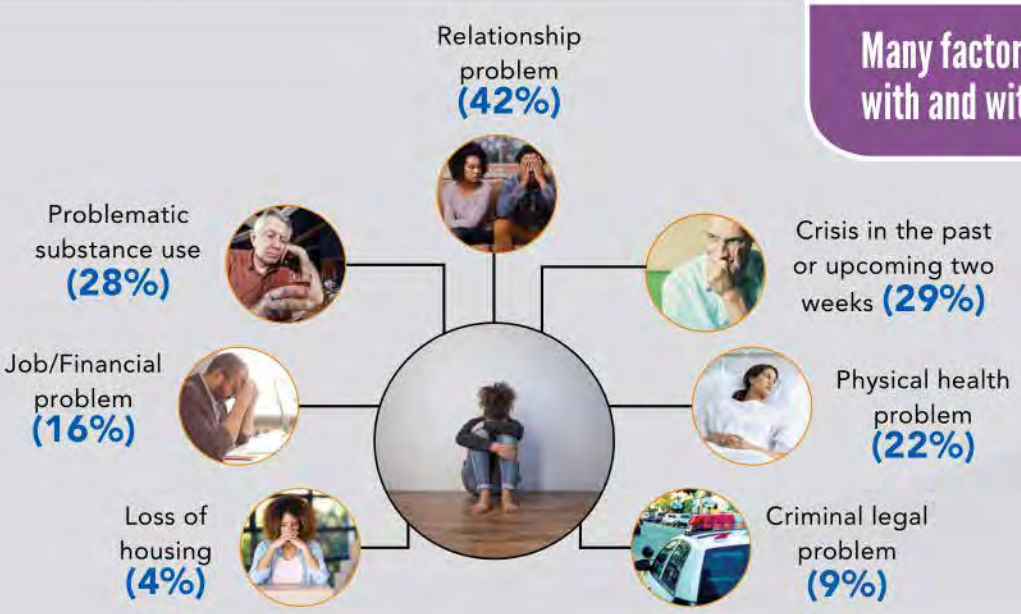
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
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Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

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Abstract

Introduction: Suicide rates in the United States have risen nearly 30% since 1999, and mental health conditions are one of several factors contributing to suicide. Examining state-level trends in suicide and the multiple circumstances contributing to it can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among persons aged ≥10 years, by state and sex, across six consecutive 3-year periods (1999–2016), were assessed using data from the National Vital Statistics System for 50 states and the District of Columbia. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health conditions.

Results: During 1999–2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases >30%. Rates increased significantly among males and females in 34 and 43 states, respectively. Fifty-four percent of decedents in 27 states in 2015 did not have a known mental health condition. Among decedents with available information, several circumstances were significantly more likely among those without known mental health conditions than among those with mental health conditions, including relationship problems/loss (45.1% versus 39.6%), life stressors (50.5% versus 47.2%), and recent/impending crises (32.9% versus 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states during 1999–2016. Various circumstances contributed to suicides among persons with and without known mental health conditions.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends and family members in the aftermath of a suicide.

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U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Introduction

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (*1*). From 1999 to 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (*2,3*). Suicide rates have also increased among persons in all age groups <75 years, with adults aged 45–64 having the largest absolute rate increase (from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (232,108) during the same period (*1,3*). Suicide is the tenth leading cause of death and is one of just three leading causes that are increasing (*1,4*). In addition, rates of emergency department visits for nonfatal self-harm, a main risk factor for suicide, increased 42% from 2001 to 2016 (*1*). Together, suicides and self-harm injuries cost the nation approximately $70 billion per year in direct medical and work loss costs (*1*).

The National Strategy for Suicide Prevention (*5*) calls for a public health approach to suicide prevention with efforts spanning multiple levels (individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is determined by multiple factors. Despite this call to action, suicide prevention largely focuses on identifying and referring suicidal persons to mental health treatment and preventing reattempts (*6*). In addition to mental health conditions and prior suicide attempts, other contributing circumstances include social and economic problems, access to lethal means (e.g., substances, firearms) among persons at risk, and poor coping and problem-solving skills (*5*). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them can help reach the national goal, established by the National Action Alliance of Suicide Prevention and the American Foundation for Suicide Prevention, of reducing the annual suicide rate 20% by 2025 (*7*). To assist states in achieving this goal, CDC analyzed state-specific trends in suicide rates and assessed the multiple contributing factors to suicide; this report presents options for strategies to include in comprehensive suicide prevention efforts that are based on the best available evidence.

Methods

Suicide rates were analyzed for persons aged ≥10 years because determining suicidal intent in younger children can be difficult (*8*). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases, Tenth Revision,* underlying-cause-of death codes X60–X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive 3-year aggregate periods spanning 1999–2016 (1999–2001; 2002–2004; 2005–2007; 2008–2010; 2011–2013; and 2014–2016). Rate estimates were age-adjusted to the U.S. 2000 standard population and expressed

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per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same 3-year data aggregates, employing weighted least-squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes.

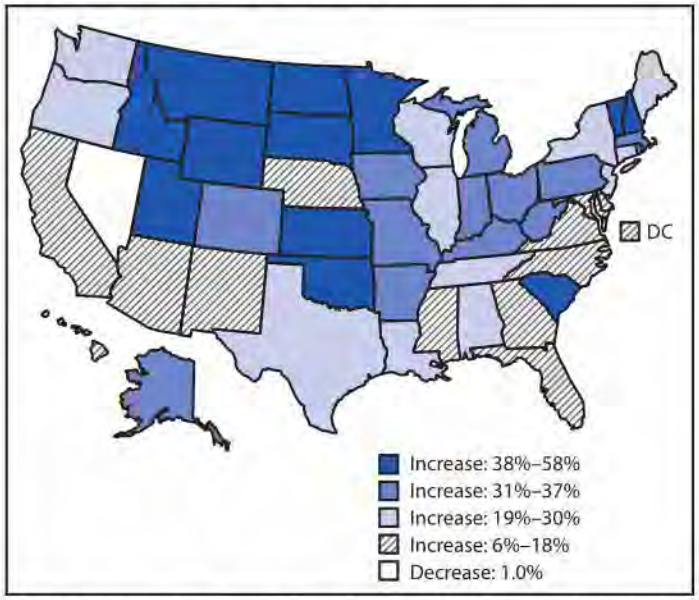
Characteristics of persons aged ≥10 years who died by suicide, with and without known mental health conditions, and the circumstances surrounding the suicides were compared in the 27 states* with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines mental health conditions as disorders and syndromes listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*9*), with the exception of problematic alcohol use and other substance use that are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. A range of circumstances (relationship problems, life stressors, and recent or impending crises) have been identified as potential risk factors for suicide in NVDRS. Circumstances captured are those identified as contributing to suicide in coroner/medical examiner or law enforcement reports, which reflect information provided by family and friends at the time of death. Decedents could have experienced multiple circumstances. Decedents with and without known mental health conditions were compared using chi-square tests. Logistic regression analyses were used to estimate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), controlling for sex, age group, and race/ethnicity.

Results

The most recent overall suicide rates (representing 2014–2016) varied fourfold, from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Across the study period, rates increased in all states except Nevada (where the rate was consistently high throughout the study period), with absolute increases ranging from 0.8 per 100,000 (Delaware) to 8.1 (Wyoming). Percentage increases in rates ranged from 5.9% (Delaware) to 57.6% (North Dakota), with increases >30% observed in 25 states (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785) (Figure).

Modeled suicide rate trends indicated significant increases in 44 states, among males (34 states) and females (43 states), as well as for the United States overall (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Nationally, the model-estimated average annual percentage change for the overall suicide rate was an increase of 1.5%. By sex, estimated national rate trends further indicated significant average annual percentage change increases for males (1.1%) and females (2.6%) (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785).

FIGURE. Percent change in annual suicide rate,* by state — United States, from 1999–2001 to 2014–2016



* Per 100,000 population, age-adjusted to the 2000 U.S. standard population.

Suicide decedents without known mental health conditions (11,039; 54.0%) were compared with those with known mental health conditions (9,407; 46.0%) for 27 states. Whereas decedents were predominantly male (76.8%) (Table 1) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely to be male (83.6% versus 68.8%; odds ratio [OR] = 2.3, 95% CI = 2.2–2.5) and belong to a racial/ethnic minority (OR range = 1.2–2.0). Suicide decedents without known mental health conditions also had significantly higher odds of perpetrating homicide followed by suicide (aOR = 2.9, 95% CI = 2.2–3.8). Among decedents aged ≥18 years, 20.1% of those without known mental health conditions and 15.3% of those with mental health conditions had previously served in the U.S. military or were serving at the time of death.

Whereas firearms were the most common method of suicide overall (48.5%), decedents without known mental health conditions were more likely to die by firearm (55.3%) and less likely to die by hanging/strangulation/suffocation (26.9%) or poisoning (10.4%) than were those with known mental health conditions (40.6%, 31.3%, and 19.8%, respectively). These differences remained significant in the adjusted models.

Toxicology testing was less likely to be performed for decedents without known mental health conditions. Among those with toxicology results, decedents without known mental health

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

TABLE 1. Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	**15,702 (76.8)**	6,469 (68.8)	9,233 (83.6)	<0.01	2.3 (2.2–2.5)	NA
Female	**4,744 (23.2)**	2,938 (31.2)	1,806 (16.4)	<0.01	0.4 (0.4–0.5)	NA
Age group (yrs)**						
10–24	**2,804 (13.7)**	1,211 (12.9)	1,593 (14.4)	<0.01	1.1 (1.1–1.2)	NA
25–44	**6,456 (31.6)**	3,036 (32.3)	3,420 (31.0)	<0.05	0.9 (0.9–1.0)	NA
45–64	**7,718 (37.7)**	3,820 (40.6)	3,898 (35.3)	<0.01	0.8 (0.8–0.8)	NA
≥65	**3,468 (17.0)**	1,340 (14.2)	2,128 (19.3)	<0.01	1.4 (1.3–1.5)	NA
Race/Ethnicity						
White, non-Hispanic	**17,102 (83.6)**	8,165 (86.8)	8,937 (81.0)	<0.01	0.6 (0.6–0.7)	NA
Black, non-Hispanic	**1,228 (6.0)**	411 (4.4)	817 (7.4)	<0.01	1.7 (1.5–2.0)	NA
American Indian/Alaska Native, non-Hispanic	**378 (1.8)**	112 (1.2)	266 (2.4)	<0.01	2.0 (1.6–2.6)	NA
Asian, non-Hispanic	**576 (2.8)**	235 (2.5)	341 (3.1)	<0.05	1.2 (1.1–1.5)	NA
Hispanic	**1,096 (5.4)**	463 (4.9)	633 (5.7)	<0.05	1.2 (1.0–1.3)	NA
Other	**66 (0.3)**	21 (0.2)	45 (0.4)	<0.05	1.8 (1.1–3.1)	NA
Extended demographics						
Ever served in military††	**3,429 (17.8)**	1,354 (15.3)	2,075 (20.1)	<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	**240 (1.2)**	104 (1.1)	136 (1.3)	NS	1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident type						
Single suicide	**20,063 (98.2)**	9,318 (99.1)	10,745 (97.4)	<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	**319 (1.6)**	64 (0.7)	255 (2.3)	<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	**64 (0.3)**	25 (0.3)	39 (0.4)	NS	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	**9,909 (48.5)**	3,821 (40.6)	6,088 (55.3)	<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	**5,907 (28.9)**	2,940 (31.3)	2,967 (26.9)	<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	**3,003 (14.7)**	1,861 (19.8)	1,142 (10.4)	<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	**1,021 (34.0)**	666 (35.8)	355 (31.1)	<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	**944 (31.4)**	608 (32.7)	336 (29.4)	NS	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	**800 (26.6)**	644 (34.6)	156 (13.7)	<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	**624 (20.8)**	468 (25.1)	156 (13.7)	<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	**219 (7.3)**	195 (10.5)	24 (2.1)	<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	**1,595 (7.8)**	780 (8.3)	815 (7.4)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)

See table footnotes on next page.

conditions were less likely to test positive for any substance overall (aOR = 0.8, 95% CI = 0.7–0.8), including opioids (aOR = 0.90, 95% CI = 0.81–0.99), but were more likely to test positive for alcohol (aOR = 1.2, 95%, CI = 1.1–1.3).

Information on circumstances surrounding suicide were available for all decedents with mental health conditions (9,407) and approximately 85% of those without known mental health conditions (9,357) in 27 states (Table 2). Persons without known mental health conditions were less likely to have any problematic substance use (aOR = 0.7, 95% CI = 0.7–0.8) than were persons with known mental health conditions. Whereas two thirds of decedents with known mental health conditions had a history of mental health or substance use treatment (67.2%), just over half (54.0%) were in treatment at the time of death.

Decedents without known mental health conditions had a significantly higher likelihood of any relationship problem/loss (45.1%) than did those with known mental health conditions (39.6%), specifically intimate partner problems (30.2% versus 24.1%), arguments/conflicts (17.5% versus 13.6%), and perpetrating interpersonal violence in the past month (3.0% versus 1.4%). Decedents without known mental health conditions were also more likely than were those with known mental health conditions to have experienced any life stressors (50.5% versus 47.2%) such as recent criminal legal problems (10.7% versus 6.2%) or eviction/loss of home (4.3% versus 3.4%) and were more likely to have had a recent or impending (within the preceding or upcoming 2 weeks, respectively) crisis (a current or acute event thought to contribute to the suicide) (32.9% versus 26.0%). All of these differences remained significant in the adjusted models. Physical health problems and job/financial problems were commonly contributing stressors among both persons without mental health conditions (23.2% and 15.6%, respectively) and those with mental health conditions (21.4%

TABLE 1. (*Continued*) Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Toxicology results						
Any toxicology testing	**13,317 (65.1)**	6,658 (70.8)	6,659 (60.3)	<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	**9,913 (74.4)**	5,192 (78.0)	4,721 (70.9)	<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected* **						
Alcohol						
Tested	**10,950 (53.6)**	5,409 (57.5)	5,541 (50.2)	<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	**4,442 (40.6)**	2,115 (39.1)	2,327 (42.0)	<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	**8,554 (41.8)**	4,258 (45.3)	4,296 (38.9)	<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	**2,279 (26.6)**	1,238 (29.1)	1,041 (24.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	**8,124 (39.7)**	4,226 (44.9)	3,898 (35.3)	<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	**2,464 (30.3)**	1,639 (38.8)	825 (21.2)	<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	**7,978 (39.0)**	3,866 (41.1)	4,112 (37.2)	<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	**499 (6.3)**	216 (5.6)	283 (6.9)	<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	**7,615 (37.2)**	3,696 (39.3)	3,919 (35.5)	<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	**736 (9.7)**	376 (10.2)	360 (9.2)	NS	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	**6,569 (32.1)**	3,127 (33.2)	3,442 (31.2)	<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	**1,471 (22.4)**	710 (22.7)	761 (22.1)	NS	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	**5,425 (26.5)**	3,103 (33.0)	2,322 (21.0)	<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	**2,214 (40.8)**	1,735 (55.9)	479 (20.6)	<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviations: CI = confidence interval; NA = not adjusted; NS = not significant; OR = odds ratio.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology testing.

*** Denominator for each positive group is the number tested for the substance in that group.

and 16.8%, respectively). Similarly, among all persons with recent crises, intimate partner problems were the most common types and did not differ by group.

Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR = 0.5, 95% CI = 0.4–0.5). Among those recently released, decedents without known mental health conditions were significantly more likely than decedents with mental health conditions to have been released from a correctional facility (25.7% versus 8.7%), hospital (43.7% versus 33.0%), or other facility, such as an alcohol/substance use treatment facility (24.2% versus 11.6%). Among decedents with known mental health conditions who were recently released from an institution, 46.7% were released from psychiatric facilities.

Decedents without known mental health conditions were significantly less likely to have a history of suicidal ideation (23.0%) or prior suicide attempts (10.3%) compared with those with known mental health conditions (40.8% and 29.4%, respectively). Suicide intent was disclosed by 22.4% and 24.5% of persons without and with known mental health conditions, respectively.

Conclusions and Comments

During 1999–2016, suicide rates increased significantly in 44 states, and 25 states experienced increases >30%. Rates increased significantly among males in 34 states, and females in 43 states. Additional research into the specific causes of these trends is needed. Data from the 27 states participating in NVDRS provide important insight into circumstances surrounding suicide and can help states identify prevention priorities.

TABLE 2. Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	**18,764 (91.8)**	9,407 (100)	9,357 (84.8)	<0.01	N/A	N/A
Mental health						
Any current diagnosed mental health condition**						
Depression/Dysthymia	—††	7,076 (75.2)	N/A	N/A	N/A	N/A
Anxiety disorder	—††	1,579 (16.8)	N/A	N/A	N/A	N/A
Bipolar disorder	—††	1,431 (15.2)	N/A	N/A	N/A	N/A
Schizophrenia	—††	509 (5.4)	N/A	N/A	N/A	N/A
PTSD	—††	424 (4.5)	N/A	N/A	N/A	N/A
ADD/ADHD	—††	226 (2.4)	N/A	N/A	N/A	N/A
Not specified	—††	760 (8.1)	N/A	N/A	N/A	N/A
Current depressed mood§§	**7,038 (37.5)**	3,962 (42.1)	3,076 (32.9)	<0.01	0.7 (0.6–0.7)	0.7 (0.6–0.7)
Problematic substance use						
Any	**5,319 (28.3)**	2,976 (31.6)	2,343 (25.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Alcohol	**3,268 (17.4)**	1,862 (19.8)	1,406 (15.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Other	**3,084 (16.4)**	1,768 (18.8)	1,316 (14.1)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Treatment						
Current mental health/substance use treatment	**5,141 (27.4)**	5,077 (54.0)	64 (0.7)	<0.01	0.01 (0.01–0.01)	0.01 (0.01–0.01)
Ever treated for mental health/substance disorder	**6,717 (35.8)**	6,323 (67.2)	394 (4.2)	<0.01	0.02 (0.02–0.02)	0.02 (0.02–0.03)
Relationship problems/loss						
Any relationship problem/loss	**7,948 (42.4)**	3,726 (39.6)	4,222 (45.1)	<0.01	1.3 (1.2–1.3)	1.3 (1.2–1.4)
Intimate partner problem	**5,098 (27.2)**	2,270 (24.1)	2,828 (30.2)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Perpetrator of interpersonal violence in past month	**414 (2.2)**	131 (1.4)	283 (3.0)	<0.01	2.2 (1.8–2.7)	2.0 (1.6–2.4)
Victim of interpersonal violence in past month	**84 (0.4)**	53 (0.6)	31 (0.3)	<0.05	0.6 (0.4–0.9)	0.8 (0.5–1.2)
Family relationship problem	**1,671 (8.9)**	873 (9.3)	798 (8.5)	NS	0.9 (0.8–1.0)	1.0 (0.9–1.1)
Other relationship problem (nonintimate)	**403 (2.1)**	202 (2.1)	201 (2.1)	NS	1.0 (0.8–1.2)	1.1 (0.9–1.3)
Argument or conflict (not specified)	**2,914 (15.5)**	1,278 (13.6)	1,636 (17.5)	<0.01	1.3 (1.2–1.5)	1.4 (1.3–1.5)
Death of a loved one (any)	**1,497 (8.0)**	826 (8.8)	671 (7.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–0.9)
Nonsuicide death	**1,181 (6.3)**	647 (6.9)	534 (5.7)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Suicide of family or friend	**379 (2.0)**	217 (2.3)	162 (1.7)	<0.01	0.7 (0.6–0.9)	0.8 (0.7–1.0)
Other life stressors						
Any life stressor	**9,171 (48.9)**	4,442 (47.2)	4,729 (50.5)	<0.01	1.1 (1.1–1.2)	1.1 (1.0–1.2)
Recent criminal legal problem	**1,588 (8.5)**	586 (6.2)	1,002 (10.7)	<0.01	1.8 (1.6–2.0)	1.7 (1.5–1.9)
Other legal problem	**748 (4.0)**	378 (4.0)	370 (4.0)	NS	1.0 (0.8–1.1)	1.0 (0.9–1.2)
Physical health problem	**4,179 (22.3)**	2,012 (21.4)	2,167 (23.2)	<0.01	1.1 (1.0–1.2)	1.0 (1.0–1.1)
Job/Financial problem¶¶	**2,941 (16.2)**	1,530 (16.8)	1,411 (15.6)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Eviction or loss of home	**722 (3.8)**	317 (3.4)	405 (4.3)	<0.01	1.3 (1.1–1.5)	1.4 (1.2–1.6)
School problem***	**162 (19.9)**	70 (17.8)	92 (21.9)	NS	1.3 (0.9–1.8)	1.3 (0.9–1.9)
Recent release from an institution†††	**1,412 (7.6)**	941 (10.2)	471 (5.1)	<0.01	0.5 (0.4–0.5)	0.5 (0.4–0.5)
Jail/Prison/Detention facility	**203 (14.4)**	82 (8.7)	121 (25.7)	<0.01	3.6 (2.7–4.9)	4.5 (3.2–6.4)
Hospital	**517 (36.6)**	311 (33.0)	206 (43.7)	<0.01	1.6 (1.3–2.0)	1.3 (1.0–1.7)
Psychiatric hospital/institution	**469 (33.2)**	439 (46.7)	30 (6.4)	<0.01	0.1 (0.1–0.1)	0.1 (0.1–0.1)
Other (includes alcohol/SU treatment facilities)	**223 (15.8)**	109 (11.6)	114 (24.2)	<0.01	2.4 (1.8–3.3)	2.5 (1.8–3.3)

See table footnotes on next page.

Suicidologists regularly state that suicide is not caused by a single factor (*5*); however, suicide prevention is often oriented toward mental health conditions alone with regard to downstream identification of suicidal persons, treatment of mental health conditions, and prevention of reattempts. This study found that approximately half of suicide decedents in NVDRS did not have a known mental health condition, indicating that additional focus on nonmental health factors further upstream could provide important information for a public health approach (*10*). Those without a known mental health condition suffered more from relationship problems and other life stressors such as criminal/legal matters, eviction/loss of home, and recent or impending crises.

Similarly, persons with mental health conditions also often experienced other circumstances such as relationship problems and job/financial or physical health problems that contributed to their suicide. These findings point to the need to both prevent the circumstances associated with the onset of mental health conditions and support persons with known mental health conditions to decrease their risk for poor outcomes (*11*). Two thirds of suicide decedents with mental health conditions had a history of treatment for mental health or substance use disorders,

TABLE 2. (*Continued*) Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Crisis within past or upcoming 2 weeks§§§	**5,525 (29.4)**	2,444 (26.0)	3,081 (32.9)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Intimate partner problem	**1,968 (35.6)**	854 (34.9)	1,114 (36.2)	NS	1.1 (0.9–1.2)	1.1 (0.9–1.2)
Physical health problem	**739 (13.4)**	315 (12.9)	424 (13.8)	NS	1.1 (0.9–1.3)	1.0 (0.8–1.2)
Criminal legal problem	**621 (11.2)**	203 (8.3)	418 (13.6)	<0.01	1.7 (1.5–2.1)	1.6 (1.3–1.9)
Family relationship problem	**430 (7.8)**	212 (8.7)	218 (7.1)	<0.05	0.8 (0.7–1.0)	0.9 (0.7–1.1)
Job problem	**354 (6.4)**	191 (7.8)	163 (5.3)	<0.01	0.7 (0.5–0.8)	0.7 (0.5–0.8)
Suicide event/history						
Left a note	**6,468 (34.5)**	3,182 (33.8)	3,286 (35.1)	NS	1.1 (1.0–1.1)	1.2 (1.1–1.2)
Disclosed suicide intent	**4,405 (23.5)**	2,306 (24.5)	2,099 (22.4)	<0.01	0.9 (0.8–1.0)	0.9 (0.8–0.9)
History of ideation	**5,990 (31.9)**	3,838 (40.8)	2,152 (23.0)	<0.01	0.4 (0.4–0.5)	0.4 (0.4–0.5)
History of attempts	**3,732 (19.9)**	2,770 (29.4)	962 (10.3)	<0.01	0.3 (0.3–0.3)	0.3 (0.3–0.3)

Abbreviations: ADD/ADHD = attention deficit disorder/attention deficit hyperactivity disorder; CI = confidence interval; N/A = not applicable; NS = not significant; OR = odds ratio; PTSD = posttraumatic stress disorder; SU = substance use.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was the reference group.

** Includes decedents with one or more diagnosed current mental health conditions, which are not mutually exclusive. Therefore, sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health conditions.

†† The specific type of mental health condition was calculated only among those with one or more known diagnosed mental health conditions.

§§ Not a diagnosis.

¶¶ Denominator is decedents aged ≥18 years.

*** Denominator is decedents aged 10–18 years.

††† Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.

§§§ Denominator of crisis subgroup is decedents with any crisis within past or upcoming 2 weeks. Crises depicted here represent the most commonly occurring categories.

with approximately half in treatment when they died. This finding suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities, such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. In addition, increased access to behavioral health providers in underserved areas is needed, as is expansion of health care systems that integrate physical and behavioral health, with a priority on suicide prevention and patient safety, especially through care transitions (*12*).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belonging and access to informational, tangible, emotional, and social support; and identifying and better supporting persons at risk (e.g., military veterans, persons with physical/mental health conditions) (*12*). Other strategies include creating protective environments (e.g., reducing access to lethal means among persons at risk for suicide, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for persons with mental health conditions and other life challenges), strengthening access to and delivery of care, supporting family and friends after a suicide, and encouraging the media to follow safe reporting recommendations (*12*). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (*10*).

The findings in this report are subject to at least three limitations. First, in the state-level analysis, rankings for four states (Maryland, Massachusetts, Rhode Island, and Utah) might have been affected by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward) or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml). Finally, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies that include more in-depth interviews with next-of-kin often identify greater attributions to mental health disorders

Summary

What is already known about this topic?

In 2016, nearly 45,000 persons died by suicide in the United States. Mental health conditions are one of several contributors to suicide.

What is added by this report?

During 1999–2016, suicide rates increased in nearly every state, including >30% increases in 25 states. 2015 data from 27 states indicate 54% of suicide decedents were not known to have mental health conditions. Relationship, substance use, health, and job or financial problems are among the other circumstances contributing to suicide.

What are the implications for public health practice?

A comprehensive approach using proven prevention strategies, such as those in CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, can help reach the national goal of reducing the annual suicide rate 20% by 2025.

(*13*); however, many methodological variations across studies exist (*14*). It is likely that some persons without known mental health conditions in the current study were experiencing mental health challenges that were unknown, undiagnosed, or not reported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (*12*) to better understand suicide in their populations, prioritize evidence-based comprehensive suicide prevention, and save lives.

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Conflict of Interest

No conflicts of interest were reported.

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Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2012–2013 and 2015–2016

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Firearm homicides and suicides represent a continuing public health concern in the United States. During 2015–2016, a total of 27,394 firearm homicides and 44,955 firearm suicides occurred among U.S. residents (1). This includes 3,224 firearm homicides and 2,118 firearm suicides among 10–19 year olds. This report updates an earlier *MMWR** that provided statistics on firearm homicides and suicides in major metropolitan areas for 2006–2007 and 2009–2010, and places continued emphasis on 10–19 year olds in recognition of the importance of early prevention efforts. Firearm homicide and suicide rates were determined for the 50 most populous U.S. metropolitan statistical areas (MSAs)† for 2012–2013 and 2015–2016 using mortality data from the National Vital Statistics System (NVSS) and population data from the U.S. Census Bureau. In contrast to the earlier report, which indicated that the all-ages firearm homicide rate had been declining both nationally and in large MSAs overall, current findings show that rates have returned to levels comparable to those observed for 2006–2007. Consistent with the earlier report, current findings show that the all-ages firearm suicide rate has continued to increase, both nationally and in large MSAs overall. Although the firearm suicide rate among 10–19 year olds remains notably lower than the all-ages rate, it has also shown continuing increases both nationally and in large MSAs collectively. These findings can inform ongoing development and monitoring of strategies directed at reducing firearm-related violence.

NVSS mortality data for 2012–2013 and 2015–2016 were used to identify firearm homicides (*International Classification of Diseases, 10th Revision* [ICD-10] underlying cause codes X93–X95 and U01.4 [provisional]) and firearm suicides (codes X72–X74) among U.S. residents. Firearm homicide and suicide counts were tabulated for county groupings forming the 50 largest MSAs (by population rank mid-year 2016).§ Tabulated counts were integrated with U.S. Census Bureau population estimates for the counties forming these MSAs to calculate annual firearm homicide rates for persons of all ages and annual firearm suicide rates for persons of all ages ≥10 years (data for persons <10 years old were excluded because intent for self-harm often is not attributed to young children). Rates were similarly calculated for 10–19 year olds. All-ages rates were age-adjusted to the year 2000 U.S. standard. MSA-level data involving firearm homicide or suicide counts <20 are not reported separately due to concerns related to statistical reliability (stability) and data privacy. However, such data were included in the calculations for all large MSAs combined.

All-ages firearm homicide rates during 2015–2016 varied widely among the 50 largest MSAs, ranging from 1.1 to 16.6 per 100,000 residents per year (Table). The rate for all large MSAs combined was 4.9, compared with a national rate of 4.4. This represents an increase from 2012–2013, when the rate for large MSAs combined was 4.1 and the national rate was 3.7. Between 2012–2013 and 2015–2016 firearm homicide rates increased for 86% of large MSAs (43 of 50) considered individually. Among 10–19 year olds the firearm homicide rate for large MSAs combined was 4.7 during 2015–2016, compared with a

national rate of 3.9. Similar to the all-ages rate, this represents an increase from 2012–2013, when the rate for large MSAs combined was 4.3 and the national rate was 3.4. Males accounted for approximately 85% of firearm homicide victims (all ages) during both reporting periods, for the 50 largest MSAs combined as well as nationally.

All-ages firearm suicide rates during 2015–2016 also varied widely by large MSA, ranging from 1.5 to 13.5 (Table). The rate for large MSAs combined was 5.8, compared with a national rate of 7.7. This represents an increase from 2012–2013, when the rate for large MSAs combined was 5.6 and the national rate was 7.4. Firearm suicide rates among 10–19 year olds remained much lower than all-ages rates. The rate for this age group for large MSAs combined was 1.9 during 2015–2016, with a national rate of 2.5. This also represents an increase from 2012–2013, when the rate for large MSAs combined was 1.5 and the national rate was 2.1. Similar to firearm homicides, males represented approximately 85% of firearm suicides (all ages) in both reporting periods, for the 50 largest MSAs combined and nationally.

Discussion

During 2015–2016, homicide was the 16th leading cause of death (all ages) in the United States and the third leading cause among 10–19 year olds; a firearm injury was the underlying cause in 74% of all homicides and in 87% of youth homicides (1). Previously observed decreases in firearm homicide rates have not continued, with more recent rates showing an increase both nationally and in large MSAs considered collectively. All-ages and youth firearm homicide rates in large MSAs overall have both remained higher than corresponding national rates.

Concurrently, suicide was the 10th leading cause of death (all ages) nationally and the second leading cause for 10–19 year olds; a firearm injury was the underlying cause in 50% of all suicides and in 42% of youth suicides (1). Previously observed increases in all-ages firearm suicide rates continued in recent years, both nationally and in large MSAs collectively; youth firearm suicide rates also showed increases both nationally and in large MSAs overall. All-ages and youth firearm suicide rates in large MSAs overall have both remained lower than national rates.

The findings in this report are subject to several limitations. First, statistics on nonfatal injuries associated with firearm assault or self-harm are not presented because population-based nonfatal injury data are not available for MSAs. Second, although the statistics presented convey the seriousness of firearm violence among 10-19 year olds, other age groups not separately considered here had higher firearm homicide rates (persons 20–44 years old) or higher firearm suicide rates (all older age groups).

It is too soon to know whether recent increases in firearm homicide rates in large MSAs, both all-ages and among youth, represent a short-term fluctuation or the beginning of a longer-term trend. From 2015 to 2016, violent crime increased for the nation (+3.8%), in cities with populations of 250,000 or more (+6.1%), in suburban areas (+2.2%) and in nonmetropolitan counties (+1.6%), suggesting a short-term increase concentrated particularly in the core cities of metropolitan areas (2). Efforts to continue to monitor this trend are important, but regardless of whether or not continued increases occur, firearm homicides are an important public health problem, particularly among young people. Preventing firearm homicides can be a challenge for cities across the country. Previous research, however, suggests that efforts to modify the physical and social environment in cities through abandoned building and vacant lot remediation, greening activities, street outreach and community norm change, low-income housing tax credits, and

business improvement districts can significantly reduce gun assaults, youth homicide, and other violent crime (3).

In contrast to homicide, rates of suicide have been increasing in the U.S. since 1999 across states, all population groups, and in rural and urban settings (4-6). Rates of firearm suicide, in particular, began increasing coincident with the economic downturn of 2007–2008 and have continued to increase despite the subsequent economic recovery. After declining 7% from 1999 to 2006, rates of firearm suicide increased 21% from 2006 to 2016 (from 6.5 to 7.8 among those aged 10 and older) (1). Urban areas recovered more quickly from the downturn than rural areas but the continued increase in rates of firearm suicide in large MSAs suggests that multiple factors are driving the increase and that a combination of prevention approaches might be necessary to reduce these risks. Efforts to strengthen household financial security, stabilize housing, teach youth coping and problem-solving skills, identify and support people at risk, and proactive prevention policies in schools, workplaces and other organizational settings are associated with reduced rates of suicide, suicide attempts, and/or co-occurring risks such as substance abuse, depression, and social isolation (7).

Another factor likely affecting both firearm homicide and suicide is access to firearms by persons at risk of harming themselves or others. Research shows that the amount of time between deciding to act and attempting suicide can be as little as 10 minutes or less and that people tend not to substitute a different method when a highly lethal method is unavailable or difficult to access (8, 9). Reducing access to lethal means during an acute suicidal crisis by safely storing firearms or temporarily removing them from the home can help reduce suicide risk, particularly among youth (7). Preventing persons convicted of or under a restraining order for domestic violence from possessing a firearm has been associated with reductions in intimate partner-related homicide, including firearm homicide (10). Efforts to strengthen the background check system to better screen for persons convicted of violent crimes or at risk of harming themselves or others may also prevent lethal firearm violence, although these policies need further study (10).

Firearm-related violence represents a continuing public health problem in the U.S., contributing substantially each year to premature death and disability. Understanding the patterns, characteristics, and impact of firearm violence is an important factor in preventing injuries and deaths.

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* Available at https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm.

† An MSA is defined by the U.S. Office of Management and Budget (OMB) as consisting of "at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties." This report is based on the revised geographic delineations for MSAs issued by OMB in August 2017.

§ The same MSAs were the 50 most populous during both reporting periods; rankings by total population changed slightly.

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Summary (Box)

What is already known about this topic?

Although firearm homicide rates in large metro areas are generally higher than for the nation overall, such rates had been declining more quickly than the national rate. In contrast, firearm suicide rates in large metro areas are generally lower than for the nation overall, but rates for both had been increasing.

What is added by this report?

In more recent years, firearm homicide rates in large metro areas and the nation overall began increasing, returning to levels comparable to those seen a decade ago. Firearm suicide rates have continued to increase in large metro areas and the nation overall.

What are the implications for public health practice?

Firearm homicides and firearm suicides represent a continuing public health concern in the U.S. Ongoing tracking of rates at all geographic levels can provide important input for initiatives directed at reducing firearm-related violence.

Dr. Redfield—National Academy of Medicine (NAM)

Action Collaborative on Countering the Opioid Epidemic

BLUF: The National Academy of Medicine (NAM), in partnership with the Aspen Institute (AI), seeks to launch a two-year Action Collaborative on countering the U.S. opioid epidemic.
ASK: Given the efforts we have underway at CDC, it would be great if either Anne Shcuchat or Deb Houry could brief the Action Collaborative on our indication specific guideline in order to inform the development of the consensus report.

Background
The Action Collaborative will be an NAM-facilitated standing body that brings together stakeholders nationally to advance progress across priority areas through collaboration, coordination, communication, and shared learning activities. These would be areas where the NAM can play an important role, and in particular, where they can help facilitate enhanced collaboration and coordination among stakeholder groups, many of which are already engaged in opioid initiatives of their own. The Collaborative membership will meet 2-3 times per year, in both public and closed sessions, with workgroups convening by phone regularly to advance the defined objectives of the Collaborative.

The feedback and data generated from NAM's early outreach efforts, including a stakeholder survey, indicated several areas the Collaborative should emphasize. These include: health professional education and training; prescribing behavior and guidelines; medical treatment, including financing and strengthening the links between medical and supportive services; community engagement and resources; culture change and stigma; and research, data, and metrics. While they will ultimately use the July meeting to affirm the Collaborative's focus areas, there is much enthusiasm and support for the Collaborative to address health professional education and training (creating an "education continuum" across UME, GME, and CME), opioid prescribing guidelines and behavior, treatment, and community-focused implementation models and resources.

The Collaborative's membership consists of individuals and entities from across the public, private, and non-governmental sectors, all working together to accelerate shared solutions and learning. Included among the entities participating are the Office of the Assistant Secretary for Health, the Food and Drug Administration, National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the American Medical Association, the Association of American Medical Colleges, the Accreditation Council for Graduate Medical Education, the Accreditation Council for Continuing Medical Education, the Council of Medical Specialty Societies, the Federation of State Medical Boards, the American Hospital Association, the Hospital Corporation of America, and Aetna. The Collaborative's membership will be finalized soon after the July 27 planning meeting. The July 27 meeting will seek to affirm the mission, goals, and objectives of the Collaborative, finalize the focus areas ("workstreams"), as well as to explore the objectives of the workstreams and potential activities to achieve those objectives.

Notes:

- Dr. Houry and Dr. Shuchat serve as CDC's representatives to NAM's Action Collaborative on countering the opioid epidemic and will participate in the kickoff on July 27th and have contributed $10k to this effort.
- Liz Finkelman (lead for this work at NAM) called into the NCIPC BSC meeting on 6/19 for the discussion on the "Methodologies for Estimating Rates of Opioid Prescribing" project.
- IF NEEDED: CDC is undertaking a new project to estimate best practice opioid prescribing in the United States. The plan is to estimate current opioid prescribing rates in the US for various conditions and procedures. Using clinical guidelines and related research, CDC will estimate what the prescribing rates

would be for these conditions and procedures if best practices were followed. Based on this information, CDC will calculate how much the current prescribing rates for acute and chronic pain would need to change across the US population to be consistent with best practices.

- This was presented to the Injury Center's Board of Scientific Counselors (BSC) last week. The BSC voted to approve the formation of the workgroup after considering comments from the public. Most of the comments were suggestions for additional experts to consider as consultants or members of the workgroup (e.g., occupational medicine, pharmacy, and behavioral health). We will consider the suggestions and fine tune the group as needed as well as how it complements the work of the Action Collaborative.
- *Does the* "Methodologies for Estimating Rates of Opioid Prescribing" *duplicate any other efforts that are underway by CDC or other agencies?*
    - To the best of CDC's knowledge, these efforts are unique to any others that are underway.
    - With regard to other efforts, CDC is aware that the National Academy of Medicine is working with FDA on a study evaluating the evidence base for existing opioid prescribing guidelines, including identification of areas where guidelines are felt to be missing but necessary.
    - To help inform this work, NAM has convened the Collaborative composed of representatives from major medical specialty societies; beyond this particular study, this Collaborative may also pursue broader research into prescribing behaviors and the role of regulation in this space, among other ideas.
    - However, to our knowledge, NAM's undertaking does *not* address CDC's primary research question addressing the differences between opioid prescribing best practices and current prescribing data at a population level, the overarching focus of our project.
    - We are not aware of any other efforts underway by other stakeholders that address our main research question.
- Related to this, we are leading a multi-HHS agency effort to (1) leverage existing guidelines to develop best practices for opioid prescribing for specific indications- and settings; (2) collaborate with AHRQ to update the evidence review around prescribing and update the CDC opioid prescribing guideline to include acute pain and specific indications as appropriate; (3) and disseminate and identify tools and resources for providers.
    - Using the clinical guidelines and related research, we will identify best practices for opioid prescribing for specific indications and for specific settings (e.g., ED visits for ankle sprains, treatment for kidney stones, and post-surgical treatments for c-sections).
    - Materials will be developed to provide clinical guidance to providers on best prescribing practices for these specific indications.

<u>NAM Forum on Mental Health and Substance Use Disorders</u>

Despite the high rates of comorbidity of physical and behavioral health conditions (which include mental health and substance-related and addictive disorders), the integration of services for these conditions into the American healthcare system has proved challenging. The Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine is developing a new Forum on Mental Health and Substance Use Disorders to address challenges in the delivery of high-quality care to individuals with these disorders that frequently intersect. The Forum will focus on data, policies, practices, and systems that affect the diagnosis and provision of care for mental health and substance use disorders. Its activities will focus on adults (including older adults) and will facilitate sustained attention to these disorders. The priorities of the Forum will be defined by the Forum members, and may evolve over time based on emerging needs and opportunities, but the overarching theme will be access to care and challenges to the integration of mental healthcare with primary and specialty care.

Forum participants will include representatives from a diverse group of stakeholders – government agencies, professional associations, consumer and advocacy groups, private foundations, private insurers, and large

pharmaceutical industry organizations. The tentative list of federal sponsoring agencies include VA, DoD, CMS, HRSA, SAMHSA and CDC. The Forum will host convening activities (primarily public workshops) and publish perspectives papers to illuminate shared challenges and potential solutions.

Notes: Dr. Althea Grant serves as CDC's representatives to the Forum. The kickoff will likely be in September 2018. CDC is contributing $50k to the effort.

Note: Mental Health and Substance Use Forum vs Action Collaborative on countering the opioid epidemic
The work of the Forum and the Collaborative will be complementary and reinforcing of one another through shared learnings, and not redundant. While the Forum will have a broader scope and tackle issues pertaining to the larger fields of mental health and substance use disorders, the Collaborative will focus solely on targeted priorities related to addressing the opioid epidemic. Members of the same, core Academies' staff team will work across these activities to ensure coordination and continuity across these activities.

Potential Research on Gun Violence

BLUF: CDC does not have specific appropriated funding to support firearm violence research and prevention. Should Congress provide CDC with funding and direction to expand this work, CDC would look to pursue research activities that align with the priorities identified in the IOM/NRC report, *Priorities for Research to Reduce the Threat of Firearm-Rated Violence*.

Appropriations

- Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control."
- This language was extended to all HHS agencies in FY 2012.
- The language **does not** prohibit CDC from conducting public health research on firearm violence.
- CDC receives its funding through the appropriation process, which provides funding by topical line item.
- We currently conduct and fund research on a variety of injury-related topics, including youth violence, child abuse and neglect, domestic violence and sexual violence.
- CDC does not have specific appropriated funding to support firearm violence research and prevention. Should Congress provide CDC with funding and direction to expand this work, CDC would look to pursue research activities that align with the priorities identified in the IOM/NRC report, *Priorities for Research to Reduce the Threat of Firearm-Rated Violence*.
    - This includes understanding the characteristics of firearm violence; the risk and protective factors for interpersonal and self-directed firearm violence; safe storage, specific populations such as children and Veterans; and the effectiveness of interventions to prevent firearm violence.
- However, CDC has and continues epi-aid investigation and analyses of data to document the public health burden of firearm injuries in the U.S.
- Firearms are also a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.
- The recently released Vital Signs on Suicide, which you'll hear more about next, is just one example of research we've done that includes a firearm component.

Surveillance

- We also collect information on firearm-related violence through national surveillance systems.
- Another system is our National Violent Death Reporting System – or NVDRS.
- NVDRS is the only state-based surveillance system that pools data on violent deaths from multiple sources into a usable, anonymous database. It captures information about the firearm used in the

violent death (e.g. type of firearm, make and model, caliber/gauge) as well as information about whether the firearm was stolen, how it was stored, and whether it belonged to the victim.

- NVDRS currently funds 40 states plus the District of Columbia and Puerto Rico, and with the increase in appropriations for FY 2018, the goal is to reach all 50 states. We have, and continue to, facilitate conversations with unfunded states to better understand what they need in order to join NVDRS, including resources, capacity, staffing, and leadership buy-in.
- We are also enhancing the NVDRS system overall, through increasing efficiency in releasing data, in allowing access to data, and in assuring completeness of data. Data collection on firearm related-variables has varied across states, so we are assisting states in improving collection of those data as well.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 21 Mar 2016 16:32:47 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: Re: For Review: The Trace-gun violence

Thank you!

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Monday, March 21, 2016 04:30 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC); Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

I think this is fine and yes attribution ok
Deb Houry, MD, MPH
Director
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
4770 Buford Highway, NE; Mail Stop F63; Atlanta, GA 30341
Twitter: @DebHouryCDC
Phone: (770) 488-4696 || Fax: (770) 488-4222

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Monday, March 21, 2016 4:03 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) ; Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Deb,
Kate Masters has come back with a follow up for you, she is publishing her piece tomorrow on CDC and gun violence research. I don't think there is anything different to say and suggest repeating pretty much what we have already said to her. Are you ok with this attributed to you? DVP has reviewed.
Thank you!
Courtney
Question for Deb: *Does she think that the CDC does enough research on gun violence and prevention? Is it doing everything it possibly can under the current circumstances?*
Proposed Ressponse:
The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. While firearm injuries are a mechanism of injury and can be examined in the context of other violence

topics, the $10 million in the President's budget request to Congress would be necessary to pursue the research priorities identified in the IOM/NRC research agenda.

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 7:01 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

See my edits below

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 4:27 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>
Subject: For Review: The Trace-gun violence

Hi Deb,

Kate Masters with The Trace requested an interview with you, originally stating she wanted to discuss: *"My article is going to be about violence research at the CDC versus the NIH, so most of my questions would center on her approach to running the Center for Injury Control and Prevention, accomplishments she's made, and priorities she'd still like to work on."*

Based on prior requests she has had with us (Wilmington and gun violence) and with NIH, I asked for specific questions that we could address via email. Here they are. Responses have been reviewed/revised with Linda Dahlberg, OPP has also been in the loop. Responses are primarily pulled from our cleared Q&A on the issue. I will also get HHS clearance once you review.

Thank you!

Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why? (approved/reviewed by Division of Population Health)

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488

Attached

Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm

Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm

Most recent NVDRS Surveillance Summary:

Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

Courtney N. Lenard, MA
Health Communication Specialist I National Center for Injury Prevention and Control I Health Communication and Science Office I O: 770.488.3733 I Monday & Friday telework: 404.808.3037

CDC 24/7
Saving Lives and Protecting People from Violence and Injury

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 10 Mar 2016 13:59:41 -0500
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC);Lane, Gabraelle (CDC/ONDIEH/NCIPC);Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC);Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR);Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Thank you, Linda! I'll see how OADC would like to handle.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 10, 2016 10:49 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) ; Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) ; Lane, Gabraelle (CDC/ONDIEH/NCIPC) ; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) ; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) ; Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
Not sure what else to say. The story they are proposing was first written by the Washington Post several months ago and has been picked up by other outlets.
Dr. Frieden noted in recent conversations with members of Congress that given the President's request for the CDC to conduct research into the causes and prevention of gun violence, it would be in CDC's best interest to have Congress appropriate funds for this work. That would make it clear that Congress wants to fund CDC to do gun violence research and would remove any ambiguity. Dr. Frieden noted that the IOM report conducted a few years ago lists many research avenues that might gain bipartisan support for research.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 10, 2016 10:32 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Good morning!
Kate Masters with The Trace has reached out again with the note below. You can see in the thread all that we have provided in the past. Aside from reiterating again, please let me know if you have any other thoughts on how to respond.
Thank you!
Courtney

From Kate:

Thanks again for all the information about the NVDRS. It was definitely helpful and that piece

should be up on our site soon. I'm emailing today because my editors and I are in the drafting phase of my piece on gun violence research at the CDC, and I wanted to let you know that the basis of the story is that the CDC is avoiding the issue of gun violence and bowing to political pressure by essentially foregoing research on firearms, even though there are things the agency could be doing. This is coming from former employees of the CDC, as well as outside gun violence researchers.

I wanted to tell you this so there would be no surprise when the article came out, and also because I wanted to give the CDC a chance to respond to what others are saying. That response could be a statement from you, or I would still love to speak with Dr. Houry directly about the lack of gun research at the Injury Center, but I do recommend addressing these statements somehow so that the CDC's voice is included in the piece.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 09, 2016 8:55 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Suggest a simple response. "We have not reached out to them specifically".

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Monday, February 08, 2016 6:14 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi-

After providing this, We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out to the NRA in recent years. Here's a follow up from The Trace:

And when you say that you have not reached out to the NRA in recent years, do you mean that you have not informed them of firearm-related articles in recent years, or you just haven't reached out to them specifically? Has the CDC always alerted stakeholders on gun violence articles?

Proposed Response:

We have not informed the NRA of firearm-related articles in recent years. As previously mentioned, we routinely alert stakeholder organizations when relevant articles are released.

Thanks much!

Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 4:01 PM

To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Works for me, although I believe the word "specifically" was deleted last time. We can save the second part if she comes back again.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:59 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Here's what we provided to AP, will the first part work?
We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out specifically to the NRA in recent years.
Mike Stobbe asked when it started/why it stopped, don't think it is necessary at this point.
Providing advance notification to NRA about forthcoming articles was done at the request of the NRA as a part of an effort to improve communication between our two organizations. We do not have documentation about when this started, but believe it was in the early 2000s. The Associate Director for Science in the National Center for Injury Prevention and Control provided advance notification of forthcoming articles, but not an advance copy of articles. The practice ended due to staff turnover in both organizations.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:35 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
I checked with Jim. He doesn't have a copy of the report.
In terms of the "gentleman's agreement" – I believe NCIPC OD prepared a response before to that question – so I defer to others to answer. It said something along the following lines: "We have not communicated with the NRA for several years"
Thanks,
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:24 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi all,

Another follow up from The Trace:

does the CDC still have a "gentleman's agreement" with the gun lobby to report out, to the lobby, any gun research completed by their grantees, whether that research was actually completed with CDC funds or not?

Also, to keep everyone in the loop, I sent Linda a separate email with this question, she and Jim are consulting.

One of the subjects for my story mentioned that in the 1990s, after the CDC Injury Center had produced/funded a number of studies about gun violence, then-CDC Director David Satcher commissioned a panel of outside experts to review that portfolio of work and make sure it wasn't biased toward gun control advocacy. The panel ultimately concluded that the studies weren't biased and were in fact extremely well done, and I was wondering if you knew of a way I could access that report so I could cite it in my article. I would love to get a copy or even the name so I can look it up myself.

Thanks you!

Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 6:10 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: Re: For Review: The Trace-gun violence

Hi Courtney,

The responses are fine.

Thank you,
Linda

Sent from my BlackBerry

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 12:49 AM Eastern Standard Time

To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR); Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Linda,
Will you please take a look at the responses and let me know if you are ok with how they read? Deb revised but unfortunately I don't have her exact changes. Looks like mainly she shortened some answers.
Thank you!
Courtney

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;

- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why? (approved/reviewed by Division of Population Health)

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached

Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm

Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm

Most recent NVDRS Surveillance Summary:

Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM

To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
See edits in red below. I didn't provide an answer for the first question. I will leave that one to someone else.
Let me know if you have any questions.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 12:09 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: For Review: The Trace-gun violence

Good afternoon,
Kate Masters with The Trace has the questions below (directed towards Deb). Kate asked us several questions about Wilmington and gun violence back in November. Please edit below and also looking for guidance on Q1 & Q3.
Thanks much!
Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. There is nothing in CDC's appropriation language that prevents the agency from conducting gun violence research. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

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initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

CDC's Behavioral Risk Factor Surveillance System (BRFSS), which provides state and national data, included questions on firearm safety in the 1990s and early 2000s. The last time firearm questions were included in the BRFSS survey was 2004. The BRFSS questionnaire is designed by a working group of BRFSS state coordinators and CDC staff. While CDC coordinates the work, the actual states run the program and have the voting rights to make additions and changes to the survey questionnaire from year to year. The Injury Center submitted a formal application to include the firearm questions on the 2016 survey. The BRFSS State Coordinators did not approve the inclusion of the firearm questions (or questions pertaining to other topics) citing concerns about the length of the current survey and declining response rates in RDD surveys in general. (making sure this is still ok with DPH)

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached

Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm

Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm
Most recent NVDRS Surveillance Summary:
Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

Courtney N. Lenard, MA
Health Communication Specialist | National Center for Injury Prevention and Control | Health Communication and Science Office | O: 770.488.3733 | Monday & Friday telework: 404.808.3037



From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 9 Feb 2016 21:40:54 +0000
To: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

You're welcome!

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 09, 2016 4:33 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Linda, I forgot to thank you…probably the millionth time ☺

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 09, 2016 8:55 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Suggest a simple response. "We have not reached out to them specifically".

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Monday, February 08, 2016 6:14 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi-
After providing this, We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out to the NRA in recent years. Here's a follow up from The Trace:
And when you say that you have not reached out to the NRA in recent years, do you mean that you have not informed them of firearm-related articles in recent years, or you just haven't reached out to them specifically? Has the CDC always alerted stakeholders on gun violence articles?
Proposed Response:
We have not informed the NRA of firearm-related articles in recent years. As previously mentioned, we routinely alert stakeholder organizations when relevant articles are released.
Thanks much!
Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 4:01 PM

To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Works for me, although I believe the word "specifically" was deleted last time. We can save the second part if she comes back again.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:59 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Here's what we provided to AP, will the first part work?
We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out specifically to the NRA in recent years.
Mike Stobbe asked when it started/why it stopped, don't think it is necessary at this point.
Providing advance notification to NRA about forthcoming articles was done at the request of the NRA as a part of an effort to improve communication between our two organizations. We do not have documentation about when this started, but believe it was in the early 2000s. The Associate Director for Science in the National Center for Injury Prevention and Control provided advance notification of forthcoming articles, but not an advance copy of articles. The practice ended due to staff turnover in both organizations.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:35 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
I checked with Jim. He doesn't have a copy of the report.
In terms of the "gentleman's agreement" – I believe NCIPC OD prepared a response before to that question – so I defer to others to answer. It said something along the following lines: "We have not communicated with the NRA for several years"
Thanks,
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:24 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi all,

Another follow up from The Trace:

does the CDC still have a "gentleman's agreement" with the gun lobby to report out, to the lobby, any gun research completed by their grantees, whether that research was actually completed with CDC funds or not?

Also, to keep everyone in the loop, I sent Linda a separate email with this question, she and Jim are consulting.

One of the subjects for my story mentioned that in the 1990s, after the CDC Injury Center had produced/funded a number of studies about gun violence, then-CDC Director David Satcher commissioned a panel of outside experts to review that portfolio of work and make sure it wasn't biased toward gun control advocacy. The panel ultimately concluded that the studies weren't biased and were in fact extremely well done, and I was wondering if you knew of a way I could access that report so I could cite it in my article. I would love to get a copy or even the name so I can look it up myself.

Thanks you!

Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 6:10 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: Re: For Review: The Trace-gun violence

Hi Courtney,

The responses are fine.

Thank you,
Linda

Sent from my BlackBerry

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 12:49 AM Eastern Standard Time

To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR); Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Linda,
Will you please take a look at the responses and let me know if you are ok with how they read? Deb revised but unfortunately I don't have her exact changes. Looks like mainly she shortened some answers.
Thank you!
Courtney

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;

- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why? (approved/reviewed by Division of Population Health)

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
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Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
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MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
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Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
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Most recent NVDRS Surveillance Summary:

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MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM

To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
See edits in red below. I didn't provide an answer for the first question. I will leave that one to someone else.
Let me know if you have any questions.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 12:09 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: For Review: The Trace-gun violence

Good afternoon,
Kate Masters with The Trace has the questions below (directed towards Deb). Kate asked us several questions about Wilmington and gun violence back in November. Please edit below and also looking for guidance on Q1 & Q3.
Thanks much!
Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. There is nothing in CDC's appropriation language that prevents the agency from conducting gun violence research. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

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initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

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CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

CDC's Behavioral Risk Factor Surveillance System (BRFSS), which provides state and national data, included questions on firearm safety in the 1990s and early 2000s. The last time firearm questions were included in the BRFSS survey was 2004. The BRFSS questionnaire is designed by a working group of BRFSS state coordinators and CDC staff. While CDC coordinates the work, the actual states run the program and have the voting rights to make additions and changes to the survey questionnaire from year to year. The Injury Center submitted a formal application to include the firearm questions on the 2016 survey. The BRFSS State Coordinators did not approve the inclusion of the firearm questions (or questions pertaining to other topics) citing concerns about the length of the current survey and declining response rates in RDD surveys in general. (making sure this is still ok with DPH)

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

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MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

Courtney N. Lenard, MA
Health Communication Specialist | National Center for Injury Prevention and Control | Health Communication and Science Office | O: 770.488.3733 | Monday & Friday telework: 404.808.3037



From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 4 Feb 2016 16:18:54 -0500
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC);Lane, Gabraelle (CDC/ONDIEH/NCIPC);Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC);Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR);Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Sounds good…thanks!

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 4:01 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) ; Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) ; Lane, Gabraelle (CDC/ONDIEH/NCIPC) ; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) ; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) ; Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Works for me, although I believe the word "specifically" was deleted last time. We can save the second part if she comes back again.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:59 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Here's what we provided to AP, will the first part work?
We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out specifically to the NRA in recent years.
Mike Stobbe asked when it started/why it stopped, don't think it is necessary at this point.
Providing advance notification to NRA about forthcoming articles was done at the request of the NRA as a part of an effort to improve communication between our two organizations. We do not have documentation about when this started, but believe it was in the early 2000s. The Associate Director for Science in the National Center for Injury Prevention and Control provided advance notification of forthcoming articles, but not an advance copy of articles. The practice ended due to staff turnover in both organizations.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:35 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>

Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –

I checked with Jim. He doesn't have a copy of the report.

In terms of the "gentleman's agreement" – I believe NCIPC OD prepared a response before to that question – so I defer to others to answer. It said something along the following lines: "We have not communicated with the NRA for several years"

Thanks,

Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:24 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi all,

Another follow up from The Trace:

does the CDC still have a "gentleman's agreement" with the gun lobby to report out, to the lobby, any gun research completed by their grantees, whether that research was actually completed with CDC funds or not?

Also, to keep everyone in the loop, I sent Linda a separate email with this question, she and Jim are consulting.

One of the subjects for my story mentioned that in the 1990s, after the CDC Injury Center had produced/funded a number of studies about gun violence, then-CDC Director David Satcher commissioned a panel of outside experts to review that portfolio of work and make sure it wasn't biased toward gun control advocacy. The panel ultimately concluded that the studies weren't biased and were in fact extremely well done, and I was wondering if you knew of a way I could access that report so I could cite it in my article. I would love to get a copy or even the name so I can look it up myself.

Thanks you!

Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 6:10 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC)

<ixn2@cdc.gov>
Subject: Re: For Review: The Trace-gun violence
Hi Courtney,

The responses are fine.

Thank you,
Linda

Sent from my BlackBerry

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 12:49 AM Eastern Standard Time
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR); Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Linda,
Will you please take a look at the responses and let me know if you are ok with how they read? Deb revised but unfortunately I don't have her exact changes. Looks like mainly she shortened some answers.
Thank you!
Courtney

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?
The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?
Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar

appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-

initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why? (approved/reviewed by Division of Population Health)

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
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MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
See edits in red below. I didn't provide an answer for the first question. I will leave that one to someone else.
Let me know if you have any questions.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 12:09 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: For Review: The Trace-gun violence

Good afternoon,
Kate Masters with The Trace has the questions below (directed towards Deb). Kate asked us several questions about Wilmington and gun violence back in November. Please edit below and also looking for guidance on Q1 & Q3.
Thanks much!
Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued.

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CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. There is nothing in CDC's appropriation language that prevents the agency from conducting gun violence research. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

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Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
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http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

Courtney N. Lenard, MA
Health Communication Specialist I National Center for Injury Prevention and Control I Health Communication and Science Office I O: 770.488.3733 I Monday & Friday telework: 404.808.3037



From: /o=cdc/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=f43dd520d1854120aa942ac284dc7713-discoverysearchmailb
Sent: 28 Aug 2018 19:24:48 +0000
To: Lenard, Courtney (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

How about- I added some edits in red- feel free to delete though

Deb Houry, MD, MPH
Director
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
4770 Buford Highway, NE; Mail Stop F63; Atlanta, GA 30341
Twitter: @DebHouryCDC
Phone: (770) 488-4696 || Fax: (770) 488-4222

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Monday, March 21, 2016 4:03 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) ; Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Deb,

Kate Masters has come back with a follow up for you, she is publishing her piece tomorrow on CDC and gun violence research. I don't think there is anything different to say and suggest repeating pretty much what we have already said to her. Are you ok with this attributed to you? DVP has reviewed.

Thank you!

Courtney

Question for Deb: *Does she think that the CDC does enough research on gun violence and prevention? Is it doing everything it possibly can under the current circumstances?*

Proposed Ressponse:

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence and would like to do more. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. While firearm injuries are a mechanism of injury and can be examined in the context of other violence topics, the $10 million in the President's budget request to Congress would be necessary to pursue the research priorities identified in the IOM/NRC research agenda.

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 7:01 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>

Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

See my edits below

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 4:27 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>
Subject: For Review: The Trace-gun violence

Hi Deb,

Kate Masters with The Trace requested an interview with you, originally stating she wanted to discuss: *"My article is going to be about violence research at the CDC versus the NIH, so most of my questions would center on her approach to running the Center for Injury Control and Prevention, accomplishments she's made, and priorities she'd still like to work on."*

Based on prior requests she has had with us (Wilmington and gun violence) and with NIH, I asked for specific questions that we could address via email. Here they are. Responses have been reviewed/revised with Linda Dahlberg, OPP has also been in the loop. Responses are primarily pulled from our cleared Q&A on the issue. I will also get HHS clearance once you review.

Thank you!

Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not

because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why? (approved/reviewed by Division of Population Health)

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached

Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm

Gang Homicides — Five U.S. Cities, 2003–2008

MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm
Most recent NVDRS Surveillance Summary:
Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

Courtney N. Lenard, MA
Health Communication Specialist I National Center for Injury Prevention and Control I Health Communication and Science
Office I O: 770.488.3733 I Monday & Friday telework: 404.808.3037



From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 4 Feb 2016 20:56:13 +0000
To: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

These reporters are driving me crazy!

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:53 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

☺. Made me laugh!

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:40 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Me either – sorry. I was nine years old at the time…

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:39 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

I remember the report, but can't recall the name of it.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:37 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Thanks Linda and Jim…do we know the name of the report?
For the second, let me look back, that was developed for the AP request. I'll send around in a minute…

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:35 PM

To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
I checked with Jim. He doesn't have a copy of the report.
In terms of the "gentleman's agreement" – I believe NCIPC OD prepared a response before to that question – so I defer to others to answer. It said something along the following lines: "We have not communicated with the NRA for several years"
Thanks,
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:24 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi all,
Another follow up from The Trace:
does the CDC still have a "gentleman's agreement" with the gun lobby to report out, to the lobby, any gun research completed by their grantees, whether that research was actually completed with CDC funds or not?
Also, to keep everyone in the loop, I sent Linda a separate email with this question, she and Jim are consulting.
One of the subjects for my story mentioned that in the 1990s, after the CDC Injury Center had produced/funded a number of studies about gun violence, then-CDC Director David Satcher commissioned a panel of outside experts to review that portfolio of work and make sure it wasn't biased toward gun control advocacy. The panel ultimately concluded that the studies weren't biased and were in fact extremely well done, and I was wondering if you knew of a way I could access that report so I could cite it in my article. I would love to get a copy or even the name so I can look it up myself.
Thanks you!
Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 6:10 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC)

<xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: Re: For Review: The Trace-gun violence

Hi Courtney,

The responses are fine.

Thank you,
Linda

Sent from my BlackBerry

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 12:49 AM Eastern Standard Time
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR); Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Linda,
Will you please take a look at the responses and let me know if you are ok with how they read? Deb revised but unfortunately I don't have her exact changes. Looks like mainly she shortened some answers.
Thank you!
Courtney

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

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Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
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CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why? (approved/reviewed by Division of Population Health)

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

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MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

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Attached

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MMWR. March 6, 2015 / 64(08);201-205

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm
Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
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Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm
Most recent NVDRS Surveillance Summary:
Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
See edits in red below. I didn't provide an answer for the first question. I will leave that one to someone else.
Let me know if you have any questions.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 12:09 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: For Review: The Trace-gun violence

Good afternoon,
Kate Masters with The Trace has the questions below (directed towards Deb). Kate asked us several questions about Wilmington and gun violence back in November. Please edit below and also looking for guidance on Q1 & Q3.
Thanks much!
Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. There is nothing in CDC's appropriation language that prevents the agency from conducting gun violence research. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

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More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the

United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

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CDC has also published a number of papers and reports. Examples listed below.

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Courtney N. Lenard, MA
Health Communication Specialist I National Center for Injury Prevention and Control I Health Communication and Science Office I O: 770.488.3733 I Monday & Friday telework: 404.808.3037



From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 4 Feb 2016 15:20:28 -0500
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Appreciate you checking! She has come back with another question that I'm not familiar with...I'll also send to the whole group.
does the CDC still have a "gentleman's agreement" with the gun lobby to report out, to the lobby, any gun research completed by their grantees, whether that research was actually completed with CDC funds or not?

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 1:53 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –

I sent Jim a message about this. I can't find anything other than reference to three investigations – GAO, National Academy of Sciences, and HHS Inspector General. I also found that Phil Cook was on the independent panel of experts to review our gun violence research portfolio – so there was a panel, just don't know if a report is available to send. It was a long time ago ☺ Hoping Jim will have some information.

Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 12:20 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Thanks, Linda!

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 12:13 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Not sure about this one – I'll do some digging to see if I can find the report referenced below.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 11:09 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC)

<xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Good morning,
Quick follow up from Kate, do you have a copy of this report or title?
One of the subjects for my story mentioned that in the 1990s, after the CDC Injury Center had produced/funded a number of studies about gun violence, then-CDC Director David Satcher commissioned a panel of outside experts to review that portfolio of work and make sure it wasn't biased toward gun control advocacy. The panel ultimately concluded that the studies weren't biased and were in fact extremely well done, and I was wondering if you knew of a way I could access that report so I could cite it in my article. I would love to get a copy or even the name so I can look it up myself.

Thank you!
Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 6:10 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: Re: For Review: The Trace-gun violence

Hi Courtney,

The responses are fine.

Thank you,
Linda

Sent from my BlackBerry

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 12:49 AM Eastern Standard Time
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR); Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Linda,
Will you please take a look at the responses and let me know if you are ok with how they read? Deb revised but unfortunately I don't have her exact changes. Looks like mainly she shortened some answers.
Thank you!
Courtney

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?
The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?
Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?
CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing

firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

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- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why? (approved/reviewed by Division of Population Health)
The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

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http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Hi Courtney –

See edits in red below. I didn't provide an answer for the first question. I will leave that one to someone else.

Let me know if you have any questions.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 12:09 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Courtney N. Lenard, MA
Health Communication Specialist I National Center for Injury Prevention and Control I Health Communication and Science Office I O: 770.488.3733 I Monday & Friday telework: 404.808.3037



From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 21 Mar 2016 16:06:56 -0400
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC);Lane, Gabraelle (CDC/ONDIEH/NCIPC);Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC);Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR);Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Got it, thank you Linda!

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, March 21, 2016 3:10 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) ; Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) ; Lane, Gabraelle (CDC/ONDIEH/NCIPC) ; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) ; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) ; Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
The response seems fine to me. See additional edits below.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Monday, March 21, 2016 2:42 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi all!
Kate Masters has come back again, she is publishing her piece tomorrow on CDC and gun violence research. Again, I don't think there is anything different to say and suggest repeating what we have already said to her. Are you ok with this?
Thank you!
Courtney
Question for Deb: *Does she think that the CDC does enough research on gun violence and prevention? Is it doing everything it possibly can under the current circumstances?*
Proposed Ressponse:
The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both

research and non-research activities. CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. While firearm injuries are a mechanism of injury and can be examined in the context of other violence topics, the $10 million in the President's budget request to Congress would be necessary to pursue the research priorities identified in the IOM/NRC research agenda.

Questions/Responses from early February:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. While firearm injuries are a mechanism of injury and can be examined in the context of other violence topics, the $10 million in the President's budget request to Congress would be necessary to pursue the research priorities identified in the IOM/NRC research agenda.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

There is nothing in the appropriations language that prohibits CDC from conducting research on gun violence. CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury

Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

Following the FY 1997 appropriation language, CDC funded investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and through its R01 grant program. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying.

CDC has also published a number of papers and reports. Examples are listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004.

In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached

Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm

Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm

Most recent NVDRS Surveillance Summary:

Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 10, 2016 10:49 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –

Not sure what else to say. The story they are proposing was first written by the Washington Post several months ago and has been picked up by other outlets.
Dr. Frieden noted in recent conversations with members of Congress that given the President's request for the CDC to conduct research into the causes and prevention of gun violence, it would be in CDC's best interest to have Congress appropriate funds for this work. That would make it clear that Congress wants to fund CDC to do gun violence research and would remove any ambiguity. Dr. Frieden noted that the IOM report conducted a few years ago lists many research avenues that might gain bipartisan support for research.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 10, 2016 10:32 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Good morning!
Kate Masters with The Trace has reached out again with the note below. You can see in the thread all that we have provided in the past. Aside from reiterating again, please let me know if you have any other thoughts on how to respond.
Thank you!
Courtney

From Kate:

Thanks again for all the information about the NVDRS. It was definitely helpful and that piece should be up on our site soon. I'm emailing today because my editors and I are in the drafting phase of my piece on gun violence research at the CDC, and I wanted to let you know that the basis of the story is that the CDC is avoiding the issue of gun violence and bowing to political pressure by essentially foregoing research on firearms, even though there are things the agency could be doing. This is coming from former employees of the CDC, as well as outside gun violence researchers.
I wanted to tell you this so there would be no surprise when the article came out, and also because I wanted to give the CDC a chance to respond to what others are saying. That response could be a statement from you, or I would still love to speak with Dr. Houry directly about the lack of gun research at the Injury Center, but I do recommend addressing these statements somehow so that the CDC's voice is included in the piece.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 09, 2016 8:55 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC)

<ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Suggest a simple response. "We have not reached out to them specifically".

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Monday, February 08, 2016 6:14 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi-

After providing this, We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out to the NRA in recent years. Here's a follow up from The Trace:

And when you say that you have not reached out to the NRA in recent years, do you mean that you have not informed them of firearm-related articles in recent years, or you just haven't reached out to them specifically? Has the CDC always alerted stakeholders on gun violence articles?

Proposed Response:

We have not informed the NRA of firearm-related articles in recent years. As previously mentioned, we routinely alert stakeholder organizations when relevant articles are released.

Thanks much!

Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 4:01 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Works for me, although I believe the word "specifically" was deleted last time. We can save the second part if she comes back again.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:59 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC)

<ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Here's what we provided to AP, will the first part work?

We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out specifically to the NRA in recent years.

Mike Stobbe asked when it started/why it stopped, don't think it is necessary at this point.

Providing advance notification to NRA about forthcoming articles was done at the request of the NRA as a part of an effort to improve communication between our two organizations. We do not have documentation about when this started, but believe it was in the early 2000s. The Associate Director for Science in the National Center for Injury Prevention and Control provided advance notification of forthcoming articles, but not an advance copy of articles. The practice ended due to staff turnover in both organizations.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:35 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –

I checked with Jim. He doesn't have a copy of the report.

In terms of the "gentleman's agreement" – I believe NCIPC OD prepared a response before to that question – so I defer to others to answer. It said something along the following lines: "We have not communicated with the NRA for several years"

Thanks,

Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:24 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi all,

Another follow up from The Trace:

does the CDC still have a "gentleman's agreement" with the gun lobby to report out, to the lobby, any gun research completed by their grantees, whether that research was actually completed with CDC funds or not?

Also, to keep everyone in the loop, I sent Linda a separate email with this question, she and Jim are consulting.

One of the subjects for my story mentioned that in the 1990s, after the CDC Injury Center had produced/funded a number of studies about gun violence, then-CDC Director David Satcher commissioned a panel of outside experts to review that portfolio of work and make sure it wasn't biased toward gun control advocacy. The panel ultimately concluded that the studies weren't biased and were in fact extremely well done, and I was wondering if you knew of a way I could access that report so I could cite it in my article. I would love to get a copy or even the name so I can look it up myself.

Thanks you!

Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 6:10 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: Re: For Review: The Trace-gun violence

Hi Courtney,

The responses are fine.

Thank you,
Linda

Sent from my BlackBerry

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 12:49 AM Eastern Standard Time
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR); Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Linda,
Will you please take a look at the responses and let me know if you are ok with how they read? Deb revised but unfortunately I don't have her exact changes. Looks like mainly she shortened some answers.
Thank you!
Courtney

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

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MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
See edits in red below. I didn't provide an answer for the first question. I will leave that one to someone else.
Let me know if you have any questions.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 12:09 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>

Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>

Subject: For Review: The Trace-gun violence

Good afternoon,

Kate Masters with The Trace has the questions below (directed towards Deb). Kate asked us several questions about Wilmington and gun violence back in November. Please edit below and also looking for guidance on Q1 & Q3.

Thanks much!

Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

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- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

CDC's Behavioral Risk Factor Surveillance System (BRFSS), which provides state and national data, included questions on firearm safety in the 1990s and early 2000s. The last time firearm

questions were included in the BRFSS survey was 2004. The BRFSS questionnaire is designed by a working group of BRFSS state coordinators and CDC staff. While CDC coordinates the work, the actual states run the program and have the voting rights to make additions and changes to the survey questionnaire from year to year. The Injury Center submitted a formal application to include the firearm questions on the 2016 survey. The BRFSS State Coordinators did not approve the inclusion of the firearm questions (or questions pertaining to other topics) citing concerns about the length of the current survey and declining response rates in RDD surveys in general. (making sure this is still ok with DPH)

***ARTICLES**

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Courtney N. Lenard, MA
Health Communication Specialist I National Center for Injury Prevention and Control I Health Communication and Science Office I O: 770.488.3733 I Monday & Friday telework: 404.808.3037



From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 3 Feb 2016 13:44:22 -0500
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: Re: For Review: The Trace-gun violence

FYI: these have been cleared.

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 08:51 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC); Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: Re: For Review: The Trace-gun violence

And assuming this needs to go up for clearance? I just want to make sure folks ok with my edits. Thx

Sent from my BlackBerry 10 smartphone.
From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 2, 2016 7:01 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC); Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

See my edits below

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 4:27 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) ; Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: For Review: The Trace-gun violence

Hi Deb,

Kate Masters with The Trace requested an interview with you, originally stating she wanted to discuss: *"My article is going to be about violence research at the CDC versus the NIH, so most of my questions would center on her approach to running the Center for Injury Control and Prevention, accomplishments she's made, and priorities she'd still like to work on."*

Based on prior requests she has had with us (Wilmington and gun violence) and with NIH, I asked for specific questions that we could address via email. Here they are. Responses have been reviewed/revised with Linda Dahlberg, OPP has also been in the loop. Responses are primarily pulled from our cleared Q&A on the issue. I will also get HHS clearance once you review.

Thank you!

Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to

repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

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Courtney N. Lenard, MA
Health Communication Specialist I National Center for Injury Prevention and Control I Health Communication and Science Office I O: 770.488.3733 I Monday & Friday telework: 404.808.3037

CDC 24/7
Saving Lives and Protecting People from Violence and Injury

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 3 Feb 2016 09:10:17 -0500
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: Re: For Review: The Trace-gun violence

Thank you!!

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 06:09 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR); Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: Re: For Review: The Trace-gun violence

Hi Courtney,

The responses are fine.

Thank you,
Linda

Sent from my BlackBerry

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 12:49 AM Eastern Standard Time
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR); Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Linda,
Will you please take a look at the responses and let me know if you are ok with how they read? Deb revised but unfortunately I don't have her exact changes. Looks like mainly she shortened some answers.
Thank you!
Courtney

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http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) ; Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) ; Lane, Gabraelle (CDC/ONDIEH/NCIPC) ; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) ; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) ; Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
See edits in red below. I didn't provide an answer for the first question. I will leave that one to someone else.
Let me know if you have any questions.
Linda

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Sent: Tuesday, February 02, 2016 12:09 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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<ixn2@cdc.gov>
Subject: For Review: The Trace-gun violence

Good afternoon,

Kate Masters with The Trace has the questions below (directed towards Deb). Kate asked us several questions about Wilmington and gun violence back in November. Please edit below and also looking for guidance on Q1 & Q3.

Thanks much!

Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. There is nothing in CDC's appropriation language that prevents the agency from conducting gun violence research. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

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CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

CDC's Behavioral Risk Factor Surveillance System (BRFSS), which provides state and national data, included questions on firearm safety in the 1990s and early 2000s. The last time firearm questions were included in the BRFSS survey was 2004. The BRFSS questionnaire is designed by a working group of BRFSS state coordinators and CDC staff. While CDC coordinates the work,

the actual states run the program and have the voting rights to make additions and changes to the survey questionnaire from year to year. The Injury Center submitted a formal application to include the firearm questions on the 2016 survey. The BRFSS State Coordinators did not approve the inclusion of the firearm questions (or questions pertaining to other topics) citing concerns about the length of the current survey and declining response rates in RDD surveys in general. (making sure this is still ok with DPH)

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Courtney N. Lenard, MA
Health Communication Specialist I National Center for Injury Prevention and Control I Health Communication and Science Office I O: 770.488.3733 I Monday & Friday telework: 404.808.3037

CDC 24/7
Saving Lives and Protecting People from Violence and Injury

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 2 Feb 2016 21:43:07 -0500
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: Re: For Review: The Trace-gun violence

Yes, I'll be sending this up for HHS clearance.

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 08:51 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC); Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: Re: For Review: The Trace-gun violence

And assuming this needs to go up for clearance? I just want to make sure folks ok with my edits. Thx

Sent from my BlackBerry 10 smartphone.
From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 2, 2016 7:01 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC); Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

See my edits below

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 4:27 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) ; Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC)
Subject: For Review: The Trace-gun violence

Hi Deb,
Kate Masters with The Trace requested an interview with you, originally stating she wanted to discuss: *"My article is going to be about violence research at the CDC versus the NIH, so most of my questions would center on her approach to running the Center for Injury Control and Prevention, accomplishments she's made, and priorities she'd still like to work on."*
Based on prior requests she has had with us (Wilmington and gun violence) and with NIH, I asked for specific questions that we could address via email. Here they are. Responses have been reviewed/revised with Linda Dahlberg, OPP has also been in the loop. Responses are primarily pulled from our cleared Q&A on the issue. I will also get HHS clearance once you review.
Thank you!
Courtney
Questions:
1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to

repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

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CDC 24/7
Saving Lives and Protecting People from Violence and Injury

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 2 Feb 2016 16:24:34 -0500
To: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC);Lane, Gabraelle (CDC/ONDIEH/NCIPC);Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC);Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR);Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Much better ☺

From: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 4:22 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
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Subject: RE: For Review: The Trace-gun violence

I don't think that answers the question, since it's not referencing the past.
How about:
There is not appropriations language that prohibits CDC from conducting public health research into gun violence, therefore we decline to comment on theoretical consequences.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 4:17 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: RE: For Review: The Trace-gun violence

For Q1, what do you think about this:
We will decline to answer this question, you may want to reach out to David Satcher, he was the CDC director during this time.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

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Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued.

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6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

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Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.

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CDC has also published a number of papers and reports. Examples listed below.

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http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

Courtney N. Lenard, MA

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CDC 24/7

Saving Lives and Protecting People
from Violence and Injury

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 2 Feb 2016 16:07:08 -0500
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Great! I'll remove the DOJ portion…thank you!

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 4:06 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Just saw the revised response from BRFSS. I'm okay with what they provided below. However, I would strike the sentence in red about contacting DOJ. DOJ doesn't have information on firearm ownership.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 2:20 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Thank you, Linda! Please see the revised response below to Q8, provided by the Division of Population Health.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 2:03 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
I'll send you a response soon. I have a few meetings until 3:30.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 12:09 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: For Review: The Trace-gun violence

Good afternoon,
Kate Masters with The Trace has the questions below (directed towards Deb). Kate asked us several questions about Wilmington and gun violence back in November. Please edit below and also looking for guidance on Q1 & Q3.
Thanks much!
Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
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CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. In order to pursue many of the research priorities identified in the IOM/NRC report commissioned by CDC, the funding requested in the FY16 President's Budget would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States.

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

CDC has focused on violence, including gun violence, as a public health problem since the early 1980s and continues to support injury surveillance activities, epi-aid investigations, and analyses of injury surveillance and other data to document the public health burden of firearm injuries in the United States. President Obama has included $10 million for CDC to conduct research into the causes and prevention of gun violence in his budget requests to Congress since FY 2014. However, Congress has not included those funds in CDC's FY 2014, FY 2015, or FY 2016 appropriation. *Please see below, examples of CDC's research.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss. You may want to touch base with Department of Justice to see if they have information on firearms ownership. You can reach them at 202-514-2007.

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CDC 24/7
Saving Lives and Protecting People from Violence and Injury

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Sent: 2 Feb 2016 16:06:39 -0500
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
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Subject: RE: For Review: The Trace-gun violence

Thank you very much, Linda! I think we can decline to answer the first one.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) ; Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
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Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
See edits in red below. I didn't provide an answer for the first question. I will leave that one to someone else.
Let me know if you have any questions.
Linda

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Health Communication Specialist I National Center for Injury Prevention and Control I Health Communication and Science Office I O: 770.488.3733 I Monday & Friday telework: 404.808.3037



From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 2 Feb 2016 19:03:15 +0000
To: Lenard, Courtney (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
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Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: For Review: The Trace-gun violence

Good afternoon,
Kate Masters with The Trace has the questions below (directed towards Deb). Kate asked us several questions about Wilmington and gun violence back in November. Please edit below and also looking for guidance on Q1 & Q3.
Thanks much!
Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?
The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence.

These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?
Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The language in CDC's appropriation does not prohibit CDC from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?
CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?
The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. In order to pursue many of the research priorities identified in the IOM/NRC report commissioned by CDC, the funding requested in the FY16 President's Budget would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?
CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States.

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

CDC has focused on violence, including gun violence, as a public health problem since the early 1980s and continues to support injury surveillance activities, epi-aid investigations, and analyses of injury surveillance and other data to document the public health burden of firearm injuries in the United States. President Obama has included $10 million for CDC to conduct research into the causes and prevention of gun violence in his budget requests to Congress since FY 2014. However, Congress has not included those funds in CDC's FY 2014, FY 2015, or FY 2016 appropriation. *Please see below, examples of CDC's research.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?
CDC's Behavioral Risk Factor Surveillance System (BRFSS), which provides state and national data, included questions on firearms in the 1990s and early 2000s. The last time firearm questions were included in the BRFSS survey was 2004. The predominant reason the questions were discontinued was because of the length of the interview. The BRFSS questionnaire is designed by a working group of BRFSS state coordinators and CDC staff. While CDC coordinates the work, the actual states run the program and have the voting rights to make additions and changes to the survey questionnaire from year to year. CDC staff asked the state coordinators to consider adding the firearm module to the fixed core in 2014 and 2015, but to date they have not been included. (making sure this is still ok with DPH)

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached

Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm

Gang Homicides — Five U.S. Cities, 2003–2008

MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm

Most recent NVDRS Surveillance Summary:
Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

Courtney N. Lenard, MA
Health Communication Specialist | National Center for Injury Prevention and Control | Health Communication and Science Office | O: 770.488.3733 | Monday & Friday telework: 404.808.3037



From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 21 Mar 2016 14:42:15 -0400
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC);Lane, Gabraelle (CDC/ONDIEH/NCIPC);Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC);Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR);Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi all!
Kate Masters has come back again, she is publishing her piece tomorrow on CDC and gun violence research. Again, I don't think there is anything different to say and suggest repeating what we have already said to her. Are you ok with this?
Thank you!
Courtney
Question for Deb: *Does she think that the CDC does enough research on gun violence and prevention? Is it doing everything it possibly can under the current circumstances?*
Proposed Ressponse:
The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.
CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States.
Questions/Responses from early February:
1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
There is not appropriations language that prohibits CDC from conducting public health research into gun violence.
2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?
The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?
Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.
4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?
CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.
5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?
The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.
6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?
More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."
7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?
Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the

Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
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Violence in the United States: Status, Challenges, and Opportunities
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Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm
Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm
Most recent NVDRS Surveillance Summary:
Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 10, 2016 10:49 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) ; Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) ; Lane, Gabraelle (CDC/ONDIEH/NCIPC) ; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) ; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) ; Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
Not sure what else to say. The story they are proposing was first written by the Washington Post several months ago and has been picked up by other outlets.
Dr. Frieden noted in recent conversations with members of Congress that given the President's request for the CDC to conduct research into the causes and prevention of gun violence, it would be in CDC's best interest to have Congress appropriate funds for this work. That would make it clear that Congress wants to fund CDC to do gun violence research and would remove any ambiguity. Dr. Frieden noted that the IOM report conducted a few years ago lists many research avenues that might gain bipartisan support for research.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 10, 2016 10:32 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Good morning!
Kate Masters with The Trace has reached out again with the note below. You can see in the thread all that we have provided in the past. Aside from reiterating again, please let me know if you have any other thoughts on how to respond.
Thank you!
Courtney
From Kate:
Thanks again for all the information about the NVDRS. It was definitely helpful and that piece should be up on our site soon. I'm emailing today because my editors and I are in the drafting

phase of my piece on gun violence research at the CDC, and I wanted to let you know that the basis of the story is that the CDC is avoiding the issue of gun violence and bowing to political pressure by essentially foregoing research on firearms, even though there are things the agency could be doing. This is coming from former employees of the CDC, as well as outside gun violence researchers.

I wanted to tell you this so there would be no surprise when the article came out, and also because I wanted to give the CDC a chance to respond to what others are saying. That response could be a statement from you, or I would still love to speak with Dr. Houry directly about the lack of gun research at the Injury Center, but I do recommend addressing these statements somehow so that the CDC's voice is included in the piece.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 09, 2016 8:55 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Suggest a simple response. "We have not reached out to them specifically".

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Monday, February 08, 2016 6:14 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi-

After providing this, We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out to the NRA in recent years. Here's a follow up from The Trace:

And when you say that you have not reached out to the NRA in recent years, do you mean that you have not informed them of firearm-related articles in recent years, or you just haven't reached out to them specifically? Has the CDC always alerted stakeholders on gun violence articles?

Proposed Response:

We have not informed the NRA of firearm-related articles in recent years. As previously mentioned, we routinely alert stakeholder organizations when relevant articles are released.

Thanks much!

Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 4:01 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC)

<jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Works for me, although I believe the word "specifically" was deleted last time. We can save the second part if she comes back again.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:59 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Here's what we provided to AP, will the first part work?
We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out specifically to the NRA in recent years.
Mike Stobbe asked when it started/why it stopped, don't think it is necessary at this point.
Providing advance notification to NRA about forthcoming articles was done at the request of the NRA as a part of an effort to improve communication between our two organizations. We do not have documentation about when this started, but believe it was in the early 2000s. The Associate Director for Science in the National Center for Injury Prevention and Control provided advance notification of forthcoming articles, but not an advance copy of articles. The practice ended due to staff turnover in both organizations.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:35 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
I checked with Jim. He doesn't have a copy of the report.
In terms of the "gentleman's agreement" – I believe NCIPC OD prepared a response before to that question – so I defer to others to answer. It said something along the following lines: "We have not communicated with the NRA for several years"
Thanks,
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:24 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi all,

Another follow up from The Trace:

does the CDC still have a "gentleman's agreement" with the gun lobby to report out, to the lobby, any gun research completed by their grantees, whether that research was actually completed with CDC funds or not?

Also, to keep everyone in the loop, I sent Linda a separate email with this question, she and Jim are consulting.

One of the subjects for my story mentioned that in the 1990s, after the CDC Injury Center had produced/funded a number of studies about gun violence, then-CDC Director David Satcher commissioned a panel of outside experts to review that portfolio of work and make sure it wasn't biased toward gun control advocacy. The panel ultimately concluded that the studies weren't biased and were in fact extremely well done, and I was wondering if you knew of a way I could access that report so I could cite it in my article. I would love to get a copy or even the name so I can look it up myself.

Thanks you!

Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 6:10 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: Re: For Review: The Trace-gun violence

Hi Courtney,

The responses are fine.

Thank you,
Linda

Sent from my BlackBerry

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 12:49 AM Eastern Standard Time

To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR); Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Linda,
Will you please take a look at the responses and let me know if you are ok with how they read? Deb revised but unfortunately I don't have her exact changes. Looks like mainly she shortened some answers.
Thank you!
Courtney

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;

- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why? (approved/reviewed by Division of Population Health)

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached

Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm

Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm

Most recent NVDRS Surveillance Summary:

Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM

To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: RE: For Review: The Trace-gun violence

Hi Courtney –
See edits in red below. I didn't provide an answer for the first question. I will leave that one to someone else.
Let me know if you have any questions.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 12:09 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: For Review: The Trace-gun violence

Good afternoon,
Kate Masters with The Trace has the questions below (directed towards Deb). Kate asked us several questions about Wilmington and gun violence back in November. Please edit below and also looking for guidance on Q1 & Q3.
Thanks much!
Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

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CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. There is nothing in CDC's appropriation language that prevents the agency from conducting gun violence research. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

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initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

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- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

CDC's Behavioral Risk Factor Surveillance System (BRFSS), which provides state and national data, included questions on firearm safety in the 1990s and early 2000s. The last time firearm questions were included in the BRFSS survey was 2004. The BRFSS questionnaire is designed by a working group of BRFSS state coordinators and CDC staff. While CDC coordinates the work, the actual states run the program and have the voting rights to make additions and changes to the survey questionnaire from year to year. The Injury Center submitted a formal application to include the firearm questions on the 2016 survey. The BRFSS State Coordinators did not approve the inclusion of the firearm questions (or questions pertaining to other topics) citing concerns about the length of the current survey and declining response rates in RDD surveys in general. (making sure this is still ok with DPH)

***ARTICLES**

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http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
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Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
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Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51

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Most recent NVDRS Surveillance Summary:
Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

Courtney N. Lenard, MA
Health Communication Specialist | National Center for Injury Prevention and Control | Health Communication and Science Office | O: 770.488.3733 | Monday & Friday telework: 404.808.3037



From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 14 Mar 2016 17:46:48 -0400
To: Mercy, James (CDC/ONDIEH/NCIPC);Reimels, Elizabeth (CDC/ONDIEH/NCIPC);Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC);Lane, Gabraelle (CDC/ONDIEH/NCIPC);Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC);Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR)
Subject: RE: For Review: The Trace-gun violence

Thanks, Jim and Beth!

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Monday, March 14, 2016 5:43 PM
To: Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Me too

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, March 14, 2016 5:18 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: RE: For Review: The Trace-gun violence

Works for me. -Beth

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Monday, March 14, 2016 5:11 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC)

<ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi All!
OADC/OD suggests the following response, is everyone comfortable with this? Particularly the last part.

> CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States.
>
> More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."
>
> The President has requested that CDC conduct research into the causes and prevention of gun violence and the IOM Report noted a number of research areas that might have bipartisan support. CDC is ready to conduct that research if funds are appropriated by Congress.

Thanks much!
Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 10, 2016 10:49 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: RE: For Review: The Trace-gun violence

Hi Courtney –

Not sure what else to say. The story they are proposing was first written by the Washington Post several months ago and has been picked up by other outlets.

Dr. Frieden noted in recent conversations with members of Congress that given the President's request for the CDC to conduct research into the causes and prevention of gun violence, it would be in CDC's best interest to have Congress appropriate funds for this work. That would make it clear that Congress

wants to fund CDC to do gun violence research and would remove any ambiguity. Dr. Frieden noted that the IOM report conducted a few years ago lists many research avenues that might gain bipartisan support for research.

Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 10, 2016 10:32 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: RE: For Review: The Trace-gun violence

Good morning!
Kate Masters with The Trace has reached out again with the note below. You can see in the thread all that we have provided in the past. Aside from reiterating again, please let me know if you have any other thoughts on how to respond.
Thank you!
Courtney
From Kate:
Thanks again for all the information about the NVDRS. It was definitely helpful and that piece should be up on our site soon. I'm emailing today because my editors and I are in the drafting phase of my piece on gun violence research at the CDC, and I wanted to let you know that the basis of the story is that the CDC is avoiding the issue of gun violence and bowing to political pressure by essentially foregoing research on firearms, even though there are things the agency could be doing. This is coming from former employees of the CDC, as well as outside gun violence researchers.
I wanted to tell you this so there would be no surprise when the article came out, and also because I wanted to give the CDC a chance to respond to what others are saying. That response could be a statement from you, or I would still love to speak with Dr. Houry directly about the lack of gun research at the Injury Center, but I do recommend addressing these statements somehow so that the CDC's voice is included in the piece.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 09, 2016 8:55 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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<ixn2@cdc.gov>
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Suggest a simple response. "We have not reached out to them specifically".

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Monday, February 08, 2016 6:14 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
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Subject: RE: For Review: The Trace-gun violence

Hi-
After providing this, We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out to the NRA in recent years. Here's a follow up from The Trace:
And when you say that you have not reached out to the NRA in recent years, do you mean that you have not informed them of firearm-related articles in recent years, or you just haven't reached out to them specifically? Has the CDC always alerted stakeholders on gun violence articles?

Proposed Response:
We have not informed the NRA of firearm-related articles in recent years. As previously mentioned, we routinely alert stakeholder organizations when relevant articles are released.

Thanks much!
Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 4:01 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Works for me, although I believe the word "specifically" was deleted last time. We can save the second part if she comes back again.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:59 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Here's what we provided to AP, will the first part work?

We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out specifically to the NRA in recent years.

Mike Stobbe asked when it started/why it stopped, don't think it is necessary at this point.
Providing advance notification to NRA about forthcoming articles was done at the request of the NRA as a part of an effort to improve communication between our two organizations. We do not have documentation about when this started, but believe it was in the early 2000s. The Associate Director for Science in the National Center for Injury Prevention and Control provided advance notification of forthcoming articles, but not an advance copy of articles. The practice ended due to staff turnover in both organizations.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:35 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –

I checked with Jim. He doesn't have a copy of the report.

In terms of the "gentleman's agreement" – I believe NCIPC OD prepared a response before to that question – so I defer to others to answer. It said something along the following lines: "We have not communicated with the NRA for several years"

Thanks,
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, February 04, 2016 3:24 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi all,
Another follow up from The Trace:
does the CDC still have a "gentleman's agreement" with the gun lobby to report out, to the lobby, any gun research completed by their grantees, whether that research was actually completed with CDC funds or not?

Also, to keep everyone in the loop, I sent Linda a separate email with this question, she and Jim are consulting.
One of the subjects for my story mentioned that in the 1990s, after the CDC Injury Center had produced/funded a number of studies about gun violence, then-CDC Director David Satcher commissioned a panel of outside experts to review that portfolio of work and make sure it wasn't biased toward gun control advocacy. The panel ultimately concluded that the studies weren't biased and were in fact extremely well done, and I was wondering if you knew of a way I could access that report so I could cite it in my article. I would love to get a copy or even the name so I can look it up myself.

Thanks you!
Courtney

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 6:10 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: Re: For Review: The Trace-gun violence

Hi Courtney,

The responses are fine.

Thank you,
Linda

Sent from my BlackBerry

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, February 03, 2016 12:49 AM Eastern Standard Time
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR); Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: For Review: The Trace-gun violence

Hi Linda,
Will you please take a look at the responses and let me know if you are ok with how they read? Deb revised but unfortunately I don't have her exact changes. Looks like mainly she shortened some answers.
Thank you!
Courtney

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?
The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?
Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an

amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* –.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?
CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?
The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?
More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?
Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-

initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why? (approved/reviewed by Division of Population Health)

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm

Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached

Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm

Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm

Most recent NVDRS Surveillance Summary:
Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 3:55 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: RE: For Review: The Trace-gun violence

Hi Courtney –

See edits in red below. I didn't provide an answer for the first question. I will leave that one to someone else.

Let me know if you have any questions.
Linda

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 02, 2016 12:09 PM

To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Williams, Alan J. (CDC/ONDIEH/NCIPC) (CTR) <wzj4@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: For Review: The Trace-gun violence

Good afternoon,
Kate Masters with The Trace has the questions below (directed towards Deb). Kate asked us several questions about Wilmington and gun violence back in November. Please edit below and also looking for guidance on Q1 & Q3.
Thanks much!
Courtney

Questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?
The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. Firearms are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?
Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued.

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. There is nothing in CDC's appropriation language that prevents the agency from conducting gun violence research. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

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Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?
CDC's Behavioral Risk Factor Surveillance System (BRFSS), which provides state and national data, included questions on firearm safety in the 1990s and early 2000s. The last time firearm questions were included in the BRFSS survey was 2004. The BRFSS questionnaire is designed by a working group of BRFSS state coordinators and CDC staff. While CDC coordinates the work, the actual states run the program and have the voting rights to make additions and changes to the survey questionnaire from year to year. The Injury Center submitted a formal application to include the firearm questions on the 2016 survey. The BRFSS State Coordinators did not approve the inclusion of the firearm questions (or questions pertaining to other topics) citing concerns about the length of the current survey and declining response rates in RDD surveys in general. (making sure this is still ok with DPH)

***ARTICLES**

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
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Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm

Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
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Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
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Most recent NVDRS Surveillance Summary:
Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

Courtney N. Lenard, MA
Health Communication Specialist | National Center for Injury Prevention and Control | Health Communication and Science Office | O: 770.488.3733 | Monday & Friday telework: 404.808.3037

CDC 24/7
Saving Lives and Protecting People from Violence and Injury

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 5 Oct 2017 10:30:14 -0400
To: Fox, Kate (CDC/ONDIEH/NCIPC);Dorigo, Leslie (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Patterson, Sara S. (CDC/ONDIEH/NCIPC)
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC);Eschelbach, Julie (CDC/ONDIEH/NCIPC);Lane, Gabraelle (CDC/ONDIEH/NCIPC);Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Cyril, Melissa R. (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Lenard, Courtney (CDC/ONDIEH/NCIPC)
Subject: RE: FYI: CNN inquiry on firearms research
Attachments: Webster and Wintemute - policy review 2015.pdf, Santaella-Tenorio et al review of firearm policies 2016.pdf, Rowhani-Rahbar et al 2016 - Safe storage review.pdf

Feel free to respond however you wish. We do have cleared Q&A related to CNN's questions (which you have shared with OADC). The state of gun violence research goes beyond CDC's work. There have been some recent reviews that might be helpful to them. Perhaps you can share them.

From: Fox, Kate (CDC/ONDIEH/NCIPC)
Sent: Thursday, October 05, 2017 10:20 AM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) ; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Patterson, Sara S. (CDC/ONDIEH/NCIPC)
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) ; Eschelbach, Julie (CDC/ONDIEH/NCIPC) ; Lane, Gabraelle (CDC/ONDIEH/NCIPC) ; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) ; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Lenard, Courtney (CDC/ONDIEH/NCIPC)
Subject: RE: FYI: CNN inquiry on firearms research

A couple of updates below to reflect updates on the PB. We could explicitly say that the request was not renewed in the FY 2018 PB, but I'm not sure that it's necessary.

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Thursday, October 5, 2017 10:15 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Patterson, Sara S. (CDC/ONDIEH/NCIPC) <afo0@cdc.gov>; Fox, Kate (CDC/ONDIEH/NCIPC) <kkj4@cdc.gov>
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Subject: FYI: CNN inquiry on firearms research

Good morning,
We have a request from reporter Susan Scutti at CNN:

Questions for CDC: it's been widely said that the CDC has neglected this area of research since the mid-1990s in response to the 1996 Omnibus Consolidated Appropriations bill for FY 1997 that stated "none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control." Yet, I also

know that the NAS released a report, "Priorities for Research to Reduce the threat of Firearm-related Violence," in June 2013 -- a task requested by the CDC. This report stemmed from President Obama's executive order earlier that year directing federal agencies to improve knowledge of this area. Essentially, then, I am wondering where the state of gun and gun violence research really stands - has gun violence research been stagnant in the US? A scan of pubmed shows some work has been done in recent years. (Basically, then, I am challenging the prevailing notion that nothing has been done - is this true?) What, if anything, came about as a result of the "Priorities for Research" report, which set out an entire research agenda? Did the CDC act on any of these recommendations? What discussions were had about the report? What insight can you provide about gun violence research since 2013? Do you wish to share any other thoughts about this topic?

I'm connecting with OADC, but I believe our response will be the one cleared by the OD yesterday:

> Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." This language was extended to all HHS agencies in FY 2012. The language does not prohibit CDC from collecting public health data on firearm violence.
>
> Firearm-related injuries are among the 5 leading causes of death for people ages 1-64 in the United States. CDC has and continues to support data collection activities and analyses to document the public health burden of firearm injuries in the U.S.

However, I also sent up to OADC what was previously used* when asked about the IOM report or Now Is the Time (appears to have been sent last in mid-January), to see if there's any part that might be used:

(b)(5)

Examples are included below.

Firearm injuries in the United States
Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133

Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm
Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm
Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm
Most recent NVDRS Surveillance Summary:
Surveillance for Violent Deaths — National Violent Death Reporting System, 17 States, 2013
MMWR August 19, 2016/65(10);1–42.
https://www.cdc.gov/mmwr/volumes/65/ss/ss6510a1.htm?s_cid=ss6510a1_w

**I know there are a couple more recent articles we could add…but wanted to see what we're able to respond with before updating.*

I'll keep you posted.

Thanks,

Leslie

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Effects of Policies Designed to Keep Firearms from High-Risk Individuals

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Keywords

gun violence, gun policy, gun safety, violence prevention

Abstract

This article summarizes and critiques available evidence from studies published between 1999 and August 2014 on the effects of policies designed to keep firearms from high-risk individuals in the United States. Some prohibitions for high-risk individuals (e.g., those under domestic violence restraining orders, violent misdemeanants) and procedures for checking for more types of prohibiting conditions are associated with lower rates of violence. Certain laws intended to prevent prohibited persons from accessing firearms—rigorous permit-to-purchase, comprehensive background checks, strong regulation and oversight of gun dealers, and requiring gun owners to promptly report lost or stolen firearms—are negatively associated with the diversion of guns to criminals. Future research is needed to examine whether these laws curtail nonlethal gun violence and whether the effects of expanding prohibiting conditions for firearm possession are modified by the presence of policies to prevent diversion.

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INTRODUCTION

The United States has an unusually high homicide rate for a high-income country—nearly six times higher than average. This discrepancy is observed only for homicides committed by firearms, for which the rate in the United States is nearly 20 times higher than the average of other high-income countries (32). Yet the United States is about average in its rate of nonfatal violent crime and aggressive behavior that do not involve firearms (18).

This disparity suggests that the availability of firearms in the United States, which is far greater than that in other high-income nations, plays an important role in the unusually high US homicide rate. Perhaps even more importantly, the United States stands out in terms of its relatively low standards for legal gun ownership and the weakness of its laws designed to prevent proscribed individuals from accessing firearms.

Many topics concerning guns in American society are contentious. These include whether widespread gun ownership serves on balance as a protection against violent crime or contributes to more violence, whether certain types of guns should be banned, and whether we should restrict legal gun owners from carrying guns—concealed or openly—in public. Yet, there is widespread support for policies designed to prevent high-risk individuals (e.g., felons, persons who are subject to a restraining order for domestic violence, individuals with serious mental illnesses) from having firearms (4). This support exists among gun owners and nonowners alike and across the spectrum of political party identification (4).

Given the lethal capacity of firearms (61) and evidence that access to firearms significantly increases risk of violence among individuals with a history of violence and criminality (8), policies designed to keep firearms from dangerous persons seem logical and have the potential to reduce violence, particularly lethal violence. The fact that a policy is logical or widely supported, of course, does not mean that it is effective or just. Sufficiently motivated and resourceful criminals could circumvent laws designed to prevent their access to firearms in a nation where gun ownership is widespread. Furthermore, firearm sales regulations could, theoretically, have harmful effects on public safety if their primary impact is to depress firearm acquisition among individuals who are at low risk for criminal misuse or suicide and who might incur safety benefits from having a firearm.

In 2005, Hahn et al. published a comprehensive review of studies on the effects of firearm laws that were published between 1979 and March 2001, which concluded that there was insufficient evidence to determine the effects of restricting firearm access for members of high-risk groups (17). More than a decade later, does this judgment stand? The current review summarizes and critiques the available evidence from studies published between 1999 and August 2014 on the effects of policies designed to keep firearms from high-risk individuals in the United States. It suggests directions for future research, given that the evidence currently available has shortcomings.

The impact of such policies is likely to be a function of two factors: how broadly policies identify and disqualify individuals at greatest risk for committing gun violence and how effective the policies are in preventing firearms from being diverted to prohibited individuals or to the underground market where criminals often acquire firearms. Thus, we have organized this review to consider, first, prohibitions for high-risk individuals, then, accountability measures to prevent guns from being diverted to prohibited persons, and finally, studies that simultaneously address both prohibitions for high-risk individuals and diversion prevention.

PROHIBITING CONDITIONS FOR FIREARM PURCHASE AND POSSESSION IN THE UNITED STATES

Federal law has established the following conditions, among others, that bar an individual from legal purchase or possession of a firearm: being convicted of any felony or a misdemeanor crime of

domestic violence; being subject to a final domestic violence restraining order; being a fugitive from justice; being adjudicated as mentally defective or involuntarily committed to a mental institution; and being addicted to or an unlawful user of controlled substances. Federal law also establishes 18 years as the minimum legal age for possessing a handgun and 21 years for purchasing a handgun from a federally licensed firearm dealer (persons ages 18–20 may purchase handguns from private parties, however).

Although each of the prohibiting conditions under federal law is defensible, in that the affected population is at elevated risk for committing violence, available evidence indicates that they would not disqualify the majority of individuals who commit gun violence. For example, in the 13 states with standards for legal gun ownership that essentially mirror or are in some cases weaker, than those set under federal law, only 40% of offenders imprisoned for crimes committed with a firearm were prohibited from possessing the type of gun they used to commit crimes (42). In these states and in many others, individuals who are under 21 years of age, who have committed serious crimes that were adjudicated in juvenile courts, or who have been convicted of misdemeanor crimes involving violence, firearms, drugs, or alcohol abuse can legally purchase and possess firearms.

Most states do have additional prohibiting conditions or stricter standards for legal gun ownership than are mandated under federal law. Many states have extended firearm prohibitions for persons subject to restraining orders for domestic violence to cover those involving dating partners and temporary restraining orders. Convictions for misdemeanor crimes of violence, extending beyond domestic partners, lead to firearm prohibitions in a few states, as can multiple convictions for alcohol-related offenses occurring within a span of 1–5 years. Most states now have temporary firearm prohibitions for individuals who committed serious crimes adjudicated in juvenile courts. Twelve states and the District of Columbia have established 21 as the minimum legal age for purchasing a handgun, even if the seller is not a licensed dealer (24).

Evidence on the Effects of Prohibiting Firearm Possession by High-Risk Individuals

Most of the available literature consists of cross-sectional or longitudinal studies of association. They have been conducted with widely varying degrees of attention to factors besides the policies under study that could have produced the observed effects. Few have incorporated any assessment of whether the policies were actively enforced. In fairness, doing so is often difficult or impossible.

Vigdor & Mercy published two studies to estimate the effects of laws designed to disarm perpetrators of domestic violence on rates of intimate partner homicides (IPHs) (40, 41). We focus on the more recent of these studies because it includes the most data, covering the years 1982 through 2002 for 46 states with complete data. The authors used state and year fixed effects and a broad range of covariates to estimate average treatment effects for 12 state laws disqualifying persons convicted of misdemeanor domestic battery from purchasing firearms, 21 state laws with domestic violence restraining order (DVRO) firearm restrictions, and 15 state laws authorizing or mandating firearm confiscation by police responding to domestic violence calls. The existence of any DVRO firearm prohibition was associated with an 8% reduction in IPH rates, and the seven state DVRO laws that prohibited both firearm purchase and possession were associated with a 10% reduction in IPH rates. Importantly, protective effects of these laws were evident only when states had sufficient records in criminal history databases used for background checks.

To rule out the possibility that DVRO firearm laws were confounded by other measures to reduce violent crime that could be affecting IPHs, Vigdor & Mercy examined whether the laws were associated with changes in stranger homicides and other measures of nonfatal violent crime,

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and they found no such association. In contrast with the findings for DVRO restrictions, neither domestic violence misdemeanor prohibitions nor laws allowing or mandating police confiscation of firearms from the scenes of domestic violence incidents were associated with changes in IPH rates.

Zeoli & Webster used the same study design to examine the same set of gun laws but used city-level data for the 46 largest US cities (60). Importantly, this study controlled for other policies that were associated with reductions in IPHs. Similar to the findings from Vigdor & Mercy, DVRO firearm restrictions were associated with a 19% reduction in IPH rates, but no effects were associated with domestic violence misdemeanor restrictions or firearm confiscation laws.

One challenge to developing valid estimates of the effects of laws establishing prohibiting conditions for firearm possession is the absence of data on whether an offender had the prohibiting condition targeted by the laws under study. A few studies are exceptions. Using data from two cohorts in California that attempted to purchase a handgun from a licensed firearm dealer, Wright et al. (59) estimated the effects of denying felons the ability to legally purchase firearms: 2,470 individuals who had one or more prior felony arrests but no felony convictions were approved for purchase, and 170 were denied when attempting to purchase handguns due to prior felony convictions (59). After controlling for prior criminal history, age, sex, and race, those who were approved to purchase a handgun were 21% more likely to be subsequently arrested for a crime involving a gun [relative risk (RR) = 1.21, 95% confidence interval (CI) 1.08–1.36] and 24% more likely to be arrested for a violent crime (RR = 1.24, 95% CI 1.11–1.39) than would have been expected had their attempt to purchase a handgun been denied based on felons' likelihood of reoffense. Of course, these findings likely suffer from selection bias and may not generalize to the larger population of felons. Felons who attempt to purchase handguns from licensed firearm dealers may have fewer connections with suppliers in underground markets than is the case for most felons and therefore may be a lower risk for violent offending.

In 1991, a California law went into effect that extended firearm prohibitions to persons convicted of misdemeanor crimes of violence. Wintemute and colleagues collected criminal history data on a retrospective, population-based cohort of persons younger than 35 years of age who sought to purchase a handgun in California in 1991 but were denied as a result of this new disqualification (57). To estimate the effect of the law, investigators contrasted criminal offending in the newly denied cohort with that of a comparison group of persons younger than 35 years of age who had been convicted of a violent misdemeanor during the 10 years prior to legally purchasing handguns in California in 1989 or 1990, just before the new law went into effect. After adjusting for differences in age, sex, and prior criminal history, those approved for handgun purchases prior to the new law were 29% more likely to be arrested for new gun and/or violent crimes during the three years following the attempted purchase than were persons denied from purchasing a handgun based on the new law (relative hazard = 1.29, 95% CI 1.04–1.60). As would be expected if handgun purchase denial, and not some other factor, had reduced violent offending, investigators saw no difference between the groups in their risk for new offenses that did not involve firearms or violence.

Marvel (26) examined the effects of state laws that prohibited juveniles (ages <18 years of age) from possessing handguns on juveniles' involvement in homicides as victims and arrestees during 1970–1999. Juvenile handgun prohibitions were unrelated to juvenile involvement in homicides in regression analyses. Many of the juvenile handgun prohibitions were enacted during the early 1990s, a time when juvenile homicide rates were peaking after surging in the late 1980s and just before a steep decline in juvenile homicides from 1994 to 1999. These dramatic changes in juvenile homicides were believed to be driven by forces that were difficult to measure (e.g., changes in drug markets, gang involvement, changes in social norms) (5) and were likely to be uneven across the

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50 states (1). Marvel's attempt to account for social forces that were not directly measured and that were unique to each state (state-specific linear terms to control for very nonlinear changes) was likely to be inadequate to avoid biases from omitted variables. Even if Marvel's null findings are valid, they may not be surprising. Risks that juveniles face when carrying handguns may not have changed significantly with the passage of juvenile handgun prohibitions. Prior to such prohibitions, juveniles could still be charged with possessing a gun outside the home without a permit to carry a concealed firearm.

Using state-level data for 50 states and the District of Columbia for the period 1979–1998, Rosengart and colleagues (33) estimated the effects of state laws that set age 21 as the minimum age for legal purchase and possession of a handgun on homicide and suicide victimization for victims under age 20. Handgun purchase and possession prohibitions for individuals under age 21 were not associated with risks for firearm-related homicides and suicides. The authors noted two limitations of the study, which may partly explain the null findings: First, only three purchase laws and one possession law had at least five years of postamendment enactment data, which limits the statistical power of the study; and second, the models are based on the assumption that the effect of each law was immediate and constant when more gradual effects may be more realistic.

Laws restricting firearm access by individuals deemed to be a threat to others or to themselves as a result of a serious mental illness have been in place for many decades. But the first rigorous study of the effects of such policies on violence was published in 2013. Swanson and colleagues obtained data for more than 23,000 individuals hospitalized in Connecticut for schizophrenia, bipolar disorder, or major depressive disorder during an eight-year period (2002–2009) and merged these records with criminal justice records for violent crime convictions. Roughly 40% of this group was found to be disqualified from legally purchasing or possessing firearms in Connecticut due to mental health adjudication, criminal offense, or both. Regression analysis, which controlled for individual risk factors, found that having a firearm-disqualifying condition was associated with a 60% increased odds of violent offending [odds ratio (OR) = 1.60, 95% CI 1.52–1.68]. However, having a disqualifying mental health condition during the period when the state was submitting relevant records to the FBI's National Instant Check System (NICS) was associated with a reduced likelihood of violent offending by a factor of 0.69 (OR = 0.69, 95% CI 0.57–0.82).

FIREARM SALES ACCOUNTABILITY POLICIES DESIGNED TO PREVENT DIVERSION OF GUNS TO PROHIBITED PERSONS

Federal Firearm Laws

Laws prohibiting firearm sales to and possession by high-risk persons may have limited impact on violence without complementary laws and regulations that provide sufficiently strong deterrents to illegal firearm transfers. The Federal Firearms Act of 1938 and the Gun Control Act (GCA) of 1968 created a rudimentary structure for accountability in the firearm industry by requiring those in the business of selling firearms to obtain a federal firearm license and by limiting interstate sales of firearms to federal firearm licensees (FFLs) (62). The GCA required firearms manufactured in or imported into the United States to have serial numbers imprinted on them and imposed record-keeping requirements that would allow law enforcement to trace firearm transfers involving licensed manufacturers, wholesalers, retailers, and retail purchasers. The GCA required individuals purchasing firearms from FFLs to sign a form stating that they were not convicted felons or otherwise disqualified under federal law. Prohibited individuals could be prosecuted for "lying and buying," but gun dealers had no obligation to verify that a purchaser was not proscribed from possessing firearms. Under the GCA, firearm transfers by private gun owners are not regulated,

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although the GCA made it a crime to transfer a firearm to someone known to be proscribed from possessing firearms (e.g., a felon).

The Brady Handgun Violence Prevention Act of 1994 mandated background checks to determine whether individuals seeking to purchase firearms from licensed gun dealers were prohibited from possessing firearms. During the initial or interim phase of the law's implementation, the background check requirement applied only to sales of handguns and included a five-day waiting period between a purchase application and delivery to approved purchasers. In December 1998, the law was fully implemented for all firearms, but the five-day waiting period was replaced with the NICS. From 1994 through 2010, NICS received more than 118 million firearm purchase applications, and 2.1 million of those requests were denied either by the FBI or by state or local law enforcement agencies processing the applications (16).

The Firearm Owners Protection Act (FOPA) was signed into federal law in 1986. The provisions of this law substantially weakened the GCA by raising the legal standard for prosecuting gun dealers who violated firearm sales laws. Prosecutors had the burden of proving not only that a violation had occurred, but that the violation was willful. Penalties for firearm sales laws violations were reduced, and law compliance inspections of licensed firearm dealers were limited. This high standard for taking legal action against licensed firearm dealers makes it easier for scofflaw or negligent gun dealers to divert or allow the diversion of large numbers of guns to criminals without incurring corrective action. Separate provisions of the FOPA raised the bar for classifying someone as "in the business of selling firearms" and thus facilitated the unregulated sale of firearms by private parties who sell a large number of firearms without a formal business. These sales proceed in most states with purchasers remaining anonymous, without background checks, and/or without record keeping. The FOPA also specifically prohibited the federal government from establishing a registry of firearm purchasers. This limitation materially affects the ability of the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) to trace firearm sales using the records of out-of-business firearm dealers.

The FOPA is not the only federal policy that has reduced retailer accountability that might otherwise prevent the diversion of guns to prohibited persons. Congress passed an amendment to an appropriations bill in 2003 that exempted the ATF's crime gun trace data from Freedom of Information Act requests, whether from public agencies or from researchers. These Tiahrt Amendments, so known in reference to their sponsor Representative Todd Tiahrt (Republican from Kansas), also mandated that information from the FBI's background checks for gun purchasers be destroyed within 24 hours of the check's completion and prevented the ATF from requiring firearm dealers to perform physical inventories during compliance audits. Provisions added to the law in subsequent years prohibited the subpoena of the ATF's crime gun trace data for use in local or state license revocations, civil lawsuits, or other administrative proceedings unless filed by the ATF.

Prior to the passage of this legislation, researchers used data from the ATF tracing of firearms recovered by police from criminals and crime scenes and made the startling finding that 1% of licensed firearm dealers accounted for more than half of the crime guns traced by the ATF in the late 1990s (36). This concentration of crime gun sales among a small number of retailers persisted even when firearm sales volume was taken into account. For these retailers, crime gun sales were not just frequent; they were disproportionate (56). In some instances, the names of gun dealers connected with the most crime guns were released to the public (28). Cities highly affected by firearm violence began to rely on the crime gun trace data to identify gun dealers to target for undercover stings and lawsuits (51).

The Protection of Lawful Commerce in Arms Act (PLCAA) was enacted in 2005 in response to lawsuits brought against gun dealers and manufacturers on the basis of claims that, among

other things, negligent sales practices by licensed firearm dealers were enabling criminals to arm themselves and contributing to gun violence. The PCLAA protected gun makers and retailers against lawsuits "resulting from the criminal or unlawful misuse of a qualified product by the person or a third party." Numerous lawsuits brought against the firearm industry were dismissed on the basis of the PCLAA (38).

Evidence on Federal Firearm Laws' Ability to Prevent Diversions to Criminals and to Reduce Violence

Considerable evidence has demonstrated that criminals and firearm traffickers regularly exploit weaknesses in federal firearm laws. A 43-state survey of licensed retailers selling at least 50 firearms annually estimated that these retailers experienced 33,800 attempted surrogate (straw) purchases, and 37,000 attempted undocumented purchases, per year (54).

The most commonly discussed weakness is the Brady Act's exemption of background checks and record keeping for firearm transfers by private gun owners. This omission hinders the ability of law enforcement to hold a gun owner accountable if he or she transfers a firearm to someone who is prohibited from owning guns. Nearly 8 out of 10 gun crime offenders participating in a national survey of state prison inmates conducted in 2004 reported that they obtained their guns from a friend, family member, or the underground gun market (50).

Firearm transactions between strangers without background checks or record keeping can be observed directly at gun shows in states that do not close the Brady Act loophole for private gun sales (52). Some unlicensed vendors at these events sell a substantial number of firearms such that it appears to be more of a livelihood than a hobby (53). It is important to emphasize that gun shows make up a small portion of the secondary gun market.

In fact, the importance of the private-seller exemption to the Brady Law in providing criminals and gun traffickers relatively low-risk access to firearms and customers is best exemplified by the enormous growth in Internet sites established to facilitate firearm sales (27). The number of guns for sale by a private seller on the popular website Armslist.com (**http://www.armslist.com**) grew more than sixfold (from 12,294 to 83,204) over a 20-month period from December 2011 to August 2013. New York City officials contracted with an investigative firm to call 125 private sellers of firearms identified on ten websites to see if they would sell their firearms when the caller said that he/she "probably couldn't pass a background check." Sixty-two percent verbally agreed to sell the firearm anyway (9). Certainly, actual criminals are using the Internet and lax or absent regulation of sales by private sellers to obtain their guns (53).

Ludwig & Cook estimated the effects of the first phase of the Brady Act using data from 1985 through 1997 with a difference-in-differences approach. They compared changes in homicide and suicide rates following the Brady Act between the 32 states directly affected by the law (Brady states) with changes in those outcomes for the 18 states that had preexisting state background check requirements (non-Brady states). Although rates of firearm-involved homicides in the United States declined following the law's implementation, differences in the reductions experienced in Brady states did not differ significantly from declines experienced in non-Brady states. There was also no overall Brady-related change in suicide rates. The authors mention several plausible reasons for the null findings: (*a*) The law exempted sales by private gun owners; (*b*) many homicide offenders do not meet any of the disqualifying conditions prior to offense and therefore are not affected by the law (11); and (*c*) probably of lesser importance, records for background checks during the time period of the study were incomplete. These authors and others have also noted that the states affected by the law had been source states for guns used in crime elsewhere. Increasing restrictions in the Brady states could therefore have reduced homicides in the non-Brady states (10).

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The FOPA may have introduced another important weakness. Firearm-related homicide rates increased dramatically, particularly among youth, in the years immediately following the enactment of the FOPA, fueled by the emergence of turbulent crack cocaine markets and a surge in gun carrying among youth (13). Many of the increasing number of guns recovered from youth connected to the illegal drug trade had likely been diverted from legal commerce. The effects of the FOPA on the diversion of guns to criminals and on gun violence have not been formally studied.

Some evidence indicates that federal laws governing licensed firearm dealers, principally the FOPA, hinder the ATF's ability to hold scofflaw dealers accountable. A study of 1,530 federal firearm trafficking investigations in the late 1990s found that corrupt or negligent licensed dealers were the leading channel for guns diverted to criminals, in some cases accounting for more than 10,000 guns (37). Anthony Braga, a leading researcher studying illegal gun trafficking who helped the ATF conduct this study, and Peter Gagliardi, a former ATF agent, wrote that federal prosecutors were able to charge a defendant with one of these violations in fewer than 38% of the cases involving dealing without a license and fewer than 45% of straw purchasing cases (6). This is in spite of the fact that ATF gun-trafficking investigators reported that gun dealing and record-keeping violations occurred in most cases accepted for prosecution. Braga & Gagliardi also underscored the difficulty in getting prosecutors to bring cases against scofflaw gun dealers and traffickers after the FOPA weakened penalties for violating the record-keeping laws necessary for preventing firearm diversions.

These roadblocks had important practical effects. Drawing on data from 1996 through 2000, National Economic Research Associates identified 120 licensed gun dealers, each of which had sold at least 200 crime guns for which traces provided evidence suggesting gun trafficking. There were 54,694 such guns in total. Of the 35 dealers with more than 500 traces of guns with one or more trafficking indicators, 32 were still open for business through the end of 2003 (30). Prosecutions of gun dealers are very rare, and imprisonment for gun trafficking is even rarer (2).

Standardized measurement and tracking of the diversion of guns to criminals are challenging. Researchers and gun-trafficking investigators at the ATF have routinely used crime gun trace data and indicators of trafficking or diversion. The most commonly used indicator of gun diversion has been an unusually short interval—ranging from less than 1 year to less than 3 years—between a gun's retail sale and its subsequent recovery by police from criminal suspects or crime scenes, a metric known as time-to-crime (TTC). A short TTC is considered an indicator of diversion, especially when the criminal possessor is someone different from the purchaser of record. Other indicators include the gun having originated from a retail sale in another state or having an obliterated serial number.

Kleck & Wong challenged the use of short TTC intervals and out-of-state origins as indicators of gun trafficking and argued that many of the flagged guns are likely stolen (22). Braga and colleagues refute these claims and defend the use of short TTC and out-of-state origins as indicators of illegal gun diversion (7). Concerns about biased results from selective tracing of crime guns can also be minimized by limiting analyses to jurisdictions and times where comprehensive gun-tracing policies are in place.

A case study from Milwaukee, Wisconsin, suggests that public transparency with crime gun trace data could encourage greater vigilance by gun dealers to prevent gun diversion and that the Tiahrt Amendments may reduce incentives for gun dealers to prevent diversions. Working with pre-Tiahrt trace data obtained from the ATF and post-Tiahrt data supplied by Milwaukee Police Department, Webster and colleagues analyzed trends in the number of crime guns deemed likely to have been diverted that were recovered by police between 1996 and 2006 (48). In May 1999, it was publicly reported that a local gun shop, Badger Guns and Ammo, had sold more guns later

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traced to crime than had any other gun store in the nation. Within days of this release, the gun store's owners announced voluntary measures to reduce the likelihood that the guns sold by the store would get into the hands of criminals. During the months just following this announcement, the number of guns sold by the store that were subsequently recovered within a year of sale by police from someone other than the purchaser of record dropped abruptly by 77% with minimal replacement by other dealers (46). But the implementation of the Tiahrt Amendments in 2003 was associated with a 200% increase in short sale-to-crime guns sold by the gun store in question, with no comparable increase for other gun dealers (46).

Law enforcement–researcher partnerships should examine whether the Tiahrt Amendments had similar effects in other US cities and whether the effects are muted in states that have their own laws for gun dealer regulation that are notably tougher than federal laws. Prior studies have shown that lawsuits brought against gun dealers facilitating blatantly illegal straw purchases significantly reduced the diversion of guns to criminals (45, 51). Now that the threat of lawsuits against gun dealers is likely to have been reduced by the PLCAA, research should examine whether gun diversions shortly following retail sales have increased.

Effects of State Gun Laws on the Diversion of Guns to Criminals and Criminal Access to Guns

The weakness in federal gun laws described above and summarized previously by Braga & Gagliardi (10) underscores the importance of studying the effects of state laws governing firearm sales. Seventeen states require individuals in the business of selling firearms to obtain licenses from state or local law enforcement agencies. Only 12 of these states and the District of Columbia also allow law enforcement to inspect gun dealers' records, however, which is a minimum requirement for firearm sales law compliance oversight (39). The number of states that have a more comprehensive set of laws and enforcement practices to promote accountability by federally licensed firearm dealers—licensing, record-keeping requirements, allowing audits of records, mandatory prompt reporting of firearm theft or loss, and conducting regular compliance audits—is dwindling to a handful (47).

Seventeen states and the District of Columbia have some requirement in place to regulate private sales of handguns, including mandatory purchaser background checks. Thirteen of these states have some form of permit-to-purchase (PTP) policies for handguns; however, these systems vary greatly in ways that are likely to affect their ability to curtail gun diversions and reduce violence. Two states allow permit seekers to apply through the mail or online, whereas all but one of the others require in-person applications with applicants being photographed and fingerprinted. Permits to purchase are valid for as long as 10 years in Illinois and Maryland and for as short as 10 days in Massachusetts and Michigan. Several states that issue permits that are valid for longer time periods have separate presale requirements for background checks, which is important because a significant percentage of those who pass a background check and purchase firearms legally become prohibited within a few years (58). Three states (Massachusetts, New Jersey, and New York) allow local law enforcement agencies issuing the permits to use discretion and to deny an applicant who does not have any explicitly stated disqualifying conditions (20).

State laws governing background check processes for firearm purchasers also differ with respect to the records that are checked. All states check the NICS; however, 19 states process background checks by state or local law enforcement agencies, which can access additional records kept by those agencies that may not be available in the NICS. The types and number of records that are available and used for background checks for firearm transfers also vary considerably across states and over time (34).

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Beginning in the late 1990s, the ATF developed a Youth Crime Gun Interdiction Initiative (YCGII) to promote comprehensive crime gun tracing in cities around the United States and the use of the data in understanding and combating illegal gun trafficking (35). About 70% of crime gun traces are for guns that originated from a retail sale in the same state in which the gun was recovered in crime. A much lower than average share of crime guns that originated from within-state retail sales suggests that the state is preventing diversions to criminals. Webster et al. analyzed crime gun trace data from the first 25 YCGII cities to examine associations between a state's gun sales regulations and the proportion of its crime guns that originated from retail sales within the state (49). The share of crime guns that originated from in-state retail sales in states with both PTP policies and handgun registration was, on average, 37 percentage points lower relative to the comparison states lacking either policy, after controlling for differences in gun ownership, proximity to population centers in other states, the prevalence of guns recovered from drug arrests (because illegal drugs and guns travel together across state lines), and in-state migration.

In a recent national study, this combination of policies, along with a comprehensive background check requirement, was also associated with fewer crime guns having a short TTC. Pierce and colleagues (31) categorized California separately because its policies for regulating firearm sales are at least as rigorous as those in many states with PTP laws. The number of short TTC (<3 years) traced crime guns bought in state per 100,000 gun owners was four times higher in states that lacked PTP or handgun registration than in California or states that had both policies. These differences between crime gun sales rates and across these gun sales law categories were even more pronounced for guns diverted to criminals across state lines (31).

Economists have examined the flow of guns purchased in one state and recovered following their use in crime in another state as a function of the difference in the stringency of gun laws in the source (exporting) state and the destination (importing) state, while controlling for other factors. Using a simple additive index of 10 gun laws identified by Mayors Against Illegal Guns as important to preventing gun trafficking,[1] Knight (23) found that weaker gun laws in source states increased the export of crime guns, and stronger gun laws in destination states increased the import of crime guns. Firearm use in crime, as measured by the percentage of robberies committed with a firearm, increased in states with relatively strong gun laws when nearby states had relatively weak gun laws. Most strongly associated with preventing the export of crime guns were laws requiring gun owners to promptly report lost or stolen firearms to law enforcement, those that provided local discretion to adopt gun laws stronger than those adopted at the state level (much of this effect may be due to Chicago's longtime ban of handguns), and state statutes specifically prohibiting straw purchases (23).

Kahane (21) conducted a study using much of the data and theoretical underpinnings as Knight did but incorporated measures relevant to the demand for guns by criminals within a state (e.g., gang members and police per capita). His findings were similar to Knight's on measures of the relative strength of gun laws in aggregate. With respect to the effects of specific laws, both studies found strong protective effects of mandatory theft and loss reporting. But Kahane's findings differed from Knight's because he did not find that local discretion to regulate gun sales was protective against exporting crime guns and did find that laws requiring background checks for

[1]The state laws examined established criminal violations for straw purchases, falsifying information on purchase applications, and firearms dealers failure to conduct background checks for firearm transfers; required background checks for all private handgun transfers or for all firearms transferred at gun shows, PTPs for handguns, and mandatory prompt reporting of lost or stolen firearms to law enforcement; allowed law enforcement inspections of firearms dealers; prohibited gun possession for violent misdemeanants; and allowed law enforcement discretion in issuing permits for concealed carry of firearms.

sales by private gun owners and allowing law enforcement discretion in issuing permits to carry concealed firearms were protective (21).

Webster and colleagues (50) studied state differences in exporting guns to criminals in other states and found that PTP laws for handguns, when law enforcement retained discretion to deny applications if deemed to be in the interest of public safety, were strongly associated with lower per capita exporting of crime guns. Nondiscretionary PTP laws that required purchasers to be fingerprinted, other requirements for background checks for private sales, mandatory reporting of theft or loss of firearms, and junk gun bans were also independently associated with fewer guns exported per capita. These analyses controlled for gun ownership, proximity to states with stronger gun laws, borders with Canada or Mexico, and out-of-state migration (50).

In another study, researchers used data from crime gun traces from 2000 to 2002 in 54 US cities with comprehensive crime gun trace policies to examine associations between the number of guns likely diverted (TTC <1 year and the criminal possessor of the gun was not the purchaser of record) and gun sales laws. Strong gun dealer regulations and oversight, required purchaser background checks for handgun sales by private owners, and PTP laws with law enforcement discretion were each independently associated with fewer diversions to criminals. Discretionary PTP laws were not independently associated with levels of gun diversions when gun ownership levels were controlled for (48).

Findings from these studies are generally consistent with economic theories relevant to regulation and market forces (12, 34, 35). Comprehensive regulations that should promote firearm seller and purchaser accountability—rigorous PTP systems, comprehensive background checks, and mandatory theft and loss reporting—appear to curtail diversions of guns to criminals, but they also lead to criminals importing guns from states with weaker gun laws. States with the strongest gun sales regulations experienced reduced availability of guns for criminal use, despite the influx of guns from other states where regulations were weaker (49).

These findings suggest that the real price of guns for criminals in states with the strongest gun laws is elevated by these states' gun policies and that criminals' demand for guns is at least somewhat elastic. This conclusion is consistent with data from an in-depth study of Chicago's underground gun market prior to the city's handgun ban being overturned by the US Supreme Court. While thousands of guns are recovered by the Chicago Police Department each year, those guns are recovered from a small fraction of the city's 2.7 million population, and a survey of adult arrestees found that only 1 in 5 male arrestees—44% of whom reported current or past gang membership—reported ever owning a handgun (12). Through hundreds of interviews with a broad range of actors in the underground economy in a high-crime Chicago neighborhood, researchers found that trusted suppliers of firearms were in short supply, and gang leaders rationed gun access among their members. There were substantial transaction costs (search time, risk encountered connecting with a supplier or purchaser), and prices paid for typically low-quality handguns were twice as high as would be found in advertisements for private sales in states with weaker gun laws than those in Illinois.

Effects on Violence of Laws Designed to Prevent the Diversion of Guns to Prohibited Persons

There are few rigorous studies of the effects of US gun policies designed to prevent the diversion of guns to prohibited persons. Most published research has examined associations between the presence of various state gun policies and rates of homicide or other violent crimes after controlling for numerous potential confounders. Most studies, however, do not estimate policy effects on the basis of changes in outcomes following changes in policy using fixed effects regression models.

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Because the most relevant gun laws (e.g., PTP handgun laws, gun dealer regulations, comprehensive background checks) have changed very little for decades, the studies are principally cross-sectional.

For example, in a state-level panel study, Irvin et al. examined the association between state laws and regulations governing firearm dealers and firearm homicide rates (19). Although the data examined spanned 1995–2010, the policies did not change over the study period. Regression analyses controlled for social and demographic characteristics, gun ownership, rates of burglaries and drug crimes (trends in these crimes would not be expected to be affected directly by firearm policies), and a global scale of gun law restrictiveness. State licensing requirements and laws requiring or allowing inspections or audits of gun dealers were independently associated with significantly lower firearm homicide rates, and these two policies combined were associated with firearm homicide rates that were 51% lower than would be expected without the policies. Although a measure of the strictness of gun laws was included in the regression models, it is likely that this factor would not completely control for confounding with the most important gun laws (e.g., PTP handgun laws, comprehensive background checks) that are correlated with gun dealer regulations.

Fleegler and colleagues analyzed the association between state firearm laws—measured as quintiles along an overall gun law strength scale developed by the Brady Campaign to Prevent Gun Violence—and firearm mortality using annual data for the years 2007–2010 (15). Poisson regression analyses controlled for population composition by age, race/ethnicity, sex, poverty, unemployment, educational attainment, population density, and rates of nonfirearm homicide and nonfirearm suicide. Compared with states in the lowest quintile on gun regulations, states in the highest quintile had firearm homicide and firearm suicide rates roughly 40% lower than would be predicted. But the only single category of gun laws that was significantly associated with firearm homicide and firearm suicide rates was for laws strengthening background checks. This subscale was weighted mostly by the presence and strength of PTP handgun laws. In addition, almost all the observed effect was on firearm suicide, though the laws under study were directed at interpersonal violence.

Independent effects of the total firearm regulation score were eliminated when the regression analyses controlled for gun ownership levels. Fleegler and colleagues interpret the findings to indicate that firearm regulation effects on firearm homicide and suicide were mediated by the laws depressing population gun ownership. But interpreting cross-sectional associations between gun laws, gun ownership, and firearm violence is difficult (55). Population gun ownership levels affect the probability of certain gun laws being enacted and few gun laws are designed, or are likely, to have significant effects on population gun ownership (discretionary PTP laws are a likely exception). Thus, the absence of firearm regulations' associations with firearm homicide and firearm suicide when gun ownership was controlled for could mean that gun ownership levels affect firearm homicide and suicide rates, and gun laws provide no protective benefits and are only spuriously associated with lower firearm mortality. This and other flaws in the Fleegler study leave much uncertainty about the utility of its findings (55).

Moorhouse & Wanner examined associations between the restrictiveness of a state's gun laws in 1998 and crime rates in 1999 and 2001 (29). Although the policies were measured prior to the outcomes, this study examined cross-sectional associations rather than changes in crime in response to changes in policies. Using similar covariates as did Fleegler et al. but adding per capita income, arrest rates, and average sentences for criminal convictions, but not controlling for gun ownership, Moorhouse & Wanner report no association between the Open Society Institute's global score for each state's gun laws and any of the violent crimes examined (murder, rape, robbery, assaults).

The reasons for the discrepant findings between the report by Fleegler et al. and the report by Moorhouse & Wanner [and similar prior studies finding no associations between gun control and violent crime (14, 25)] are not obvious. Here we focus on differences between the outcome measures and how gun regulations were measured. Moorhouse & Wanner examined violent crimes that, all but murder, typically do not involve use of a firearm. In contrast, Fleegler et al. and Irvin et al. focused exclusively on lethal violence committed with firearms. It is not surprising that outcomes that exclusively measure firearm violence would be more closely correlated with firearm policies than would outcomes where most incidents do not involve a firearm.

The measures of gun policies used in each study are also problematic. These studies and many others used scales purporting to measure the restrictiveness of gun laws. These scales generally reflect the political priorities of gun control advocates rather than a scientifically valid measure of a construct. The scales are often not weighted to reflect the size of the effect each element is expected to have. Furthermore, using such a blunt measure does not allow researchers to examine whether the effectiveness of certain policies (e.g., prohibitions for violent misdemeanants) depends on the presence of other policies (e.g., comprehensive background checks). For example, an index made up of 20 largely ineffective policies and 3 effective policies is likely to produce null findings. Findings from global measures of gun laws also prevent inferences about the effects of any single policy.

One of the stronger studies to consider both the type and the breadth of disqualifications for firearm possession as well as the strength of regulations designed to prevent transfers to prohibited persons is Andres & Hempstead's study of the effects of state gun policies on suicide rates for males (3).[2] In a 50-state panel study covering 1995–2004, they found that an index of behavioral (versus criminal) prohibitions relevant to risk for suicide (e.g., restrictions for mental illness, domestic violence, alcohol and drug convictions) and a measure that combined PTP requirements and minimum purchase age 21 were each associated with lower suicide rates. There was no association between criminal prohibitions and suicides. These analyses controlled for social and economic variables, alcohol consumption, and a proxy for firearm ownership. The researchers used state and year fixed effects to control for time-invariant omitted variables specific to states and omitted variables over time nationally.

Although there has been relatively little change in key state policies designed to prevent guns from being diverted to prohibited persons in recent decades, there have been some expansions to prohibiting conditions and improvements in the databases used to determine firearm purchaser eligibility. Sen & Panjamapirom examined state-level associations between variations in the types of records for prohibiting conditions that were accessed for pregun-sale background checks and firearm deaths for the period 1996–2005 (39). Analyses controlled for changes in population demographics, poverty, unemployment, divorce, hunting licenses (a proxy for gun ownership), alcohol consumption, whether a state required background checks prior to the Brady Act, year and region fixed effects, and a lagged value of the outcome variable for 1990. More extensive background checks were associated with lower rates of homicide overall, firearm homicide, and firearm suicide. Expanded checks for domestic violence restraining orders, fugitive status, and mental illness disqualifiers were each independently associated with lower rates of firearm homicides and all homicides. Expanded checks for mental illness disqualifications and fugitive status were each associated with lower rates of firearm suicides and all suicides. The magnitude of the estimated effects was greatest among outcomes for firearm homicide. The size of these estimated effects, however, seems questionably large. For example, restraining order laws are principally

[2]The analyses were limited to males because the vast majority of firearm suicides are by males.

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applicable to domestic violence, which accounts for less than 10% of murders, yet background checks for restraining orders were associated with a 13% lower risk for firearm homicides. The study's exclusive focus on categories of background checks without controlling for other policies is likely to have inflated estimates of the effects of background checks.

For the research reviewed above, the type of firearm policy most consistently associated with curtailing the diversion of guns to criminals and for which some evidence indicates protective effects against gun violence is PTP for handguns. Most states with PTP laws have had them in place for many decades. The most recent change was Missouri's 2007 repeal of its PTP handgun law. Webster et al. studied the effects of this policy on lethal violence with a 50-state panel study using data for the period 1999–2012 (43). Regression analyses controlled for state and year fixed effects and changes in unemployment, poverty, policing levels, incarceration, burglary rates (as a general measure of crime), and policies concerning the ease of getting concealed weapons permits, junk gun bans, and so-called "Stand Your Ground" laws. Homicide rates based on vital records and murder rates based on police reports showed diverging trends immediately following the PTP repeal; rates rose sharply in Missouri but declined in the rest of the nation. Missouri's PTP repeal was associated with a 14% increase in murder rates over 5 years following the policy change and a 25% increase in firearm homicide rates. Additional evidence bolstered causal inference between the policy change and increased murders: (*a*) Increases in firearm homicide rates were widespread and relatively even across metropolitan counties in the state (ruling out the possibility that the increase was due to some change in one large jurisdiction); (*b*) there was no policy-related change in nonfirearm homicides; and (*c*) there was a twofold increase in short TTC guns and a relatively large shift from out-of-state sources of crime guns to within-state crime guns immediately following the repeal.

CONCLUSION

The weaknesses in US federal firearm policies are well documented and result in many high-risk individuals having access to and using firearms to commit violent crimes. Roughly half or more of those who commit gun crimes do not meet any of the prohibiting conditions under federal law. Weak federal laws and declining resources for federal gun law enforcement limit the ATF's ability to curtail illegal firearm trafficking. The enactment of the Brady Handgun Violence Prevention Act was a step in the direction of increased accountability to prevent prohibited persons from obtaining firearms, but it did not have a significant impact on population homicide or suicide rates during the first four years it was in place. Yet on a more micro level, it appears that criminals who attempt to purchase firearms from licensed gun dealers and are denied are less likely to engage in violent crime. Expansions in the types of background checks performed may also have protective effects against lethal violence. Some expansions in the conditions that disqualify someone from legally possessing firearms—restraining orders for domestic violence and convictions for misdemeanor crimes of violence—seem to reduce violence. Others (e.g., minimum age for purchase or possession of handguns, misdemeanors for domestic violence) have not influenced violent crime.

Mounting evidence indicates that certain laws intended to increase the accountability of firearm sellers to avoid risky transfers of firearms are effective in curtailing the diversion of guns to criminals, in particular the more rigorous PTP handgun laws, comprehensive background checks, strong regulation and oversight of gun dealers, and laws requiring gun owners to promptly report lost or stolen firearms. Evidence that lower levels of guns being diverted to criminals will translate into less gun violence is less robust, but it appears that rigorous PTP handgun laws are protective against homicides and suicides. Future research should examine whether these laws also curtail nonlethal gun violence. Laws mandating comprehensive background check requirements

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for firearm purchasers through means other than PTP laws should be studied with respect to both their enforcement as well as their impact on violence. Such studies should consider the effects of complementary policies such as penalties for failure to comply with firearm sales laws, explicit prohibitions on straw purchases, and mandatory loss and theft reporting. Finally, it is surprising that prior studies have not systematically examined if and how policy effects are modified by the presence of other policies. For example, the impact of a law expanding firearm prohibitions to violent misdemeanants may depend on whether the state has a robust system of laws in place to prevent diversions. Similarly, the impact of antidiversion laws such as comprehensive background checks should depend on the breadth of the prohibitions for high-risk individuals. Given the importance of gun violence to public safety in the United States, greater investment in and commitment to rigorous research are needed to answer these and other important questions relevant to the prevention of gun violence.

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Annual Review of Public Health
Volume 36, 2015

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An online log of corrections to *Annual Review of Public Health* articles may be found at http://www.annualreviews.org/errata/publhealth

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What Do We Know About the Association Between Firearm Legislation and Firearm-Related Injuries?

Julian Santaella-Tenorio*, Magdalena Cerdá, Andrés Villaveces, and Sandro Galea

* Correspondence to Dr. Julian Santaella-Tenorio, Department of Epidemiology, Mailman School of Public Health, Columbia University, 722 West 168th Street, Room 515, New York, NY 10032 (e-mail: js4222@cumc.columbia.edu).

Accepted for publication September 4, 2015.

Firearms account for a substantial proportion of external causes of death, injury, and disability across the world. Legislation to regulate firearms has often been passed with the intent of reducing problems related to their use. However, lack of clarity around which interventions are effective remains a major challenge for policy development. Aiming to meet this challenge, we systematically reviewed studies exploring the associations between firearm-related laws and firearm homicides, suicides, and unintentional injuries/deaths. We restricted our search to studies published from 1950 to 2014. Evidence from 130 studies in 10 countries suggests that in certain nations the simultaneous implementation of laws targeting multiple firearms restrictions is associated with reductions in firearm deaths. Laws restricting the purchase of (e.g., background checks) and access to (e.g., safer storage) firearms are also associated with lower rates of intimate partner homicides and firearm unintentional deaths in children, respectively. Limitations of studies include challenges inherent to their ecological design, their execution, and the lack of robustness of findings to model specifications. High quality research on the association between the implementation or repeal of firearm legislation (rather than the evaluation of existing laws) and firearm injuries would lead to a better understanding of what interventions are likely to work given local contexts. This information is key to move this field forward and for the development of effective policies that may counteract the burden that firearm injuries pose on populations.

death; firearms; homicide; legislation; suicide; weapons; wounds and injuries

Abbreviations: NCHS, National Center for Health Statistics; NFA, National Firearms Agreement; UCR, Uniform Crime Reports.

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Effectiveness of Interventions to Promote Safe Firearm Storage

Ali Rowhani-Rahbar*, Joseph A. Simonetti, and Frederick P. Rivara

* Correspondence to Dr. Ali Rowhani-Rahbar, Box 357236, Department of Epidemiology, School of Public Health, University of Washington, Seattle, WA 98195 (e-mail: rowhani@uw.edu).

Accepted for publication July 27, 2015.

Despite supportive evidence for an association between safe firearm storage and lower risk of firearm injury, the effectiveness of interventions that promote such practices remains unclear. Guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist, we conducted a systematic review of randomized and quasi-experimental controlled studies of safe firearm storage interventions using a prespecified search of 9 electronic databases with no restrictions on language, year, or location from inception through May 27, 2015. Study selection and data extraction were independently performed by 2 investigators. The Cochrane Collaboration's domain-specific tool for assessing risk of bias was used to evaluate the quality of included studies. Seven clinic- and community-based studies published in 2000–2012 using counseling with or without safety device provision met the inclusion criteria. All 3 studies that provided a safety device significantly improved firearm storage practices, while 3 of 4 studies that provided no safety device failed to show an effect. Heterogeneity of studies precluded conducting a meta-analysis. We discuss methodological considerations, gaps in the literature, and recommendations for conducting future studies. Although additional studies are needed, the totality of evidence suggests that counseling augmented by device provision can effectively encourage individuals to store their firearms safely.

firearms; program evaluation; safety

Abbreviations: DVRO, domestic violence restraining order; IPH, intimate partner homicide; IPV, intimate partner violence.

INTRODUCTION

According to the Centers for Disease Control and Prevention, about 118,000 Americans including 18,000 individuals younger than 20 years of age sustained fatal or nonfatal firearm injuries in 2013 (1). Such injuries lead to substantial mortality, psychological and physical morbidity, and high costs resulting from medical expenses, reduced productivity, and diminished quality of life (2–7). Gun ownership is an independent risk factor for firearm injury (8–16), and estimates indicate that guns are present in about one third of US households (17, 18). However, only a few interventions aimed at limiting firearm ownership have been tested (19–21), and such prevention strategies remain socially and politically contentious. Some studies have also suggested that gun owners prefer not to be asked to remove firearms from their homes (22, 23).

Notably, more than one half of US households store a gun unlocked and/or loaded (17, 24), which provides an opportunity to pursue other strategies to prevent firearm injuries. Safe storage, including methods such as keeping guns unloaded, locked, and separate from locked ammunition, has been widely endorsed as a firearm injury prevention strategy by medical professional societies (25–27). Several firearm advocacy organizations have also encouraged some form of safety practices as an integral element of responsible gun ownership (28–30). Importantly, adult patients and parents of pediatric patients do not seem to be bothered by conversations about guns (22, 23, 31), and the concept of safe firearm storage has enjoyed broad public support (32).

Case-control and cross-sectional studies among children and adults have consistently shown a lower risk of self-inflicted firearm injuries and deaths in households that practice safe storage compared with those in which guns are stored unlocked and/or loaded (9–11, 13, 15, 33, 34), although some of those studies were limited by insufficient statistical power (9, 10, 34). In addition, a study of a nationally representative sample of suicide decedents found that individuals living in households with safe storage practices were less likely to commit suicide using a firearm (35). This finding is notable because of the importance of specifically preventing *firearm-related* suicide attempts since the case fatality of those (85%) is greater than that of other methods such as suffocation (69%)

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From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 1 Aug 2016 20:35:14 +0000
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: F/U - GAO

You're welcome.

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 4:35 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: F/U - GAO

Thank you very much!

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 4:34 PM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: F/U - GAO

Yes – that's the one.

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 4:34 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Subject: RE: F/U - GAO

Thanks Linda- the Rowhani article correct?

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 4:27 PM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: F/U - GAO

It's the systematic review on safe storage. It was included in the attachments sent last week.

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 4:26 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Subject: RE: F/U - GAO

Just got one follow up item:
Janean (CDC GAO) also had that we were going to include a study on provision of safety device which IOM identified as gap area. Is that one of the attachments you sent last week?
Thanks!

Elizabeth

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 1:12 PM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: F/U - GAO

Sure – here you go.

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 11:48 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Subject: RE: F/U - GAO

Would you mind sharing your notes with me that you used for the call? I won't send them anywhere or use them for anything, I just want to reread what you said for my own long term FA knowledge.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 11:46 AM
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: RE: F/U - GAO

Thank you, Elizabeth!

From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 11:31 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Doyle, Nadine (CDC/ONDIEH/NCIPC) <hvx8@cdc.gov>
Subject: RE: F/U - GAO

Thanks so much Linda! Malia forwarded it all to me last week and I sent it up right away. I will let you know if I hear anything else from them.
You did a fantastic job on Thursday! I really appreciate all your help on this.

Elizabeth

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 11:29 AM
To: Doyle, Nadine (CDC/ONDIEH/NCIPC) <hvx8@cdc.gov>
Cc: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: FW: F/U - GAO

FYI

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, July 28, 2016 4:30 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Subject: F/U - GAO

Hi Malia –
Here's follow-up materials to send up to the Center, including the response to Q4 about the impact of the Dickey amendment (attached) and the summary report from the Federal Partner Meeting (also attached).

Federal Partner Meeting (summary report attached)
CDC and the CDC Foundation co-sponsored a two-day convening of stakeholders partners from multiple federal agencies in Washington, DC on February 19-20, 2014. Representatives from the Departments of Education, HHS, and DOJ, met in Washington, D.C. to discuss current efforts and future opportunities associated with firearm violence prevention research. The meeting objectives were to:

1. Discuss approaches for strengthening data to understand patterns and characteristics of firearm violence and to address research questions
2. Discuss ways to ensure that the research carried out by the different agencies is complementary and builds upon individual and collective strengths
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Systematic reviews (firearm laws and safe storage) -- attached

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IOM Papers:

The papers were presented during the IOM's Means of Violence Workshop held December 18, 2014 and are included as "attachments" to the Workshop Summary Report. Direct links to the paper are below (http://nationalacademies.org/hmd/activities/global/violenceforum/2014-dec-18.aspx).

Direct Links to the Papers:

http://iom.nationalacademies.org/~/media/Files/Activity%20Files/Global/2014-DEC-18/Alcohol-Firearms.pdf.

http://nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Youth-Acquisition-Carrying-Firearms-US.pdf

http://iom.nationalacademies.org/~/media/Files/Activity%20Files/Global/2014-DEC-18/Firearms-Suicide-Homicide.pdf.

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From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: 1 Aug 2016 16:26:14 -0400
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: F/U - GAO

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http://nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Youth-Acquisition-Carrying-Firearms-US.pdf

http://iom.nationalacademies.org/~/media/Files/Activity%20Files/Global/2014-DEC-18/Firearms-Suicide-Homicide.pdf.

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From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 1 Aug 2016 17:11:46 +0000
To: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Subject: RE: F/U - GAO
Attachments: GAO Request- Firearm Safety and Public Health.docx

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From: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 11:31 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Doyle, Nadine (CDC/ONDIEH/NCIPC) <hvx8@cdc.gov>
Subject: RE: F/U - GAO

Thanks so much Linda! Malia forwarded it all to me last week and I sent it up right away. I will let you know if I hear anything else from them.
You did a fantastic job on Thursday! I really appreciate all your help on this.

Elizabeth

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, August 01, 2016 11:29 AM
To: Doyle, Nadine (CDC/ONDIEH/NCIPC) <hvx8@cdc.gov>
Cc: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>
Subject: FW: F/U - GAO

FYI

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, July 28, 2016 4:30 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Subject: F/U - GAO

Hi Malia –
Here's follow-up materials to send up to the Center, including the response to Q4 about the impact of the Dickey amendment (attached) and the summary report from the Federal Partner Meeting (also attached).
Federal Partner Meeting (summary report attached)
CDC and the CDC Foundation co-sponsored a two-day convening of stakeholders partners from multiple federal agencies in Washington, DC on February 19-20, 2014. Representatives from the Departments of

Education, HHS, and DOJ, met in Washington, D.C. to discuss current efforts and future opportunities associated with firearm violence prevention research. The meeting objectives were to:

1. Discuss approaches for strengthening data to understand patterns and characteristics of firearm violence and to address research questions
2. Discuss ways to ensure that the research carried out by the different agencies is complementary and builds upon individual and collective strengths
3. Identify opportunities to collaborate on current or future efforts

Systematic reviews (firearm laws and safe storage) -- attached

- Santaella-Tenorio et al. What do we know about the association between firearm legislation and firearm-related injuries? *Epidemiologic Reviews,* 2016; 38:140–157.
- Ali Rowhani-Rahbar et al. Effectiveness of interventions to promote safe firearm storage. *Epidemiologic Reviews,* 2016; doi:10.1093/epirev/mxv006

CDC paper:

- Fowler K, Dahlberg LL, Haileyesus T, Annest JL, Bacon S. Firearm injuries in the United States. *Preventive Medicine* 2015; 79:5-14. (attached)

Paper on the pilot study related to lethal means counseling and safe storage of medications and firearms

- Runyan, C. W., Becker, A., Brandspigel, S., Barber, C., Trudeau, A., & Novins, D. (2016). Lethal Means Counseling for Parents of Youth Seeking Emergency Care for Suicidality. *West J Emerg Med, 17*(1), 8-14. doi: 10.5811/westjem.2015.11.28590 (attached)

IOM Papers:

The papers were presented during the IOM's Means of Violence Workshop held December 18, 2014 and are included as "attachments" to the Workshop Summary Report. Direct links to the paper are below (http://nationalacademies.org/hmd/activities/global/violenceforum/2014-dec-18.aspx).

Direct Links to the Papers:

http://iom.nationalacademies.org/~/media/Files/Activity%20Files/Global/2014-DEC-18/Alcohol-Firearms.pdf.

http://nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Youth-Acquisition-Carrying-Firearms-US.pdf

http://iom.nationalacademies.org/~/media/Files/Activity%20Files/Global/2014-DEC-18/Firearms-Suicide-Homicide.pdf.

Linda L. Dahlberg, Ph.D.
Senior Advisor to the Director
Division of Violence Prevention
CDC/ONDIEH/NCIPC
4770 Buford Highway, NE., MS-F64
Atlanta, GA 30341
Tel: 770-488-4496
Fax: 770-488-4349
Email: ldahlberg@cdc.gov



From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 29 Jul 2016 08:15:15 -0400
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: F/U - GAO

Thanks Linda! We'll forward these resources.

Malia

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Thursday, July 28, 2016 4:30 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Cc: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: F/U - GAO

Hi Malia –

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http://iom.nationalacademies.org/~/media/Files/Activity%20Files/Global/2014-DEC-18/Firearms-Suicide-Homicide.pdf.

Linda L. Dahlberg, Ph.D.
Senior Advisor to the Director
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Atlanta, GA 30341
Tel: 770-488-4496
Fax: 770-488-4349
Email: ldahlberg@cdc.gov

CDC 24/7
Saving Lives and Protecting People from Violence and Injury

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 23 Feb 2018 17:13:54 +0000
To: Roby, Sarah (CDC/ONDIEH/NCIPC)
Subject: RE: Gun violence research by the government hasn't been funded in two decades. But that may soon change.

I'm glad.

From: Roby, Sarah (CDC/ONDIEH/NCIPC)
Sent: Friday, February 23, 2018 9:29 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: Re: Gun violence research by the government hasn't been funded in two decades. But that may soon change.

Hi Tom,

Thank you so much for sending this. It renewed my optimism for the day ☺

Sarah

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, February 23, 2018 8:47:37 AM
To: Sileno, Samantha (CDC/ONDIEH/NCIPC); Dennehy, Heather (CDC/ONDIEH/NCIPC); Roby, Sarah (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Black, Erin (CDC/ONDIEH/NCIPC)
Subject: FW: Gun violence research by the government hasn't been funded in two decades. But that may soon change.

FYI

From: DIANA H FISHBEIN [mailto:dfishbein@psu.edu]
Sent: Thursday, February 22, 2018 1:04 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: FW: Gun violence research by the government hasn't been funded in two decades. But that may soon change.

This would be huge if it came to fruition!

Diana H. Fishbein, Ph.D.
Professor, Department of Human Development and Family Studies
Director, Program for Translational Research on Adversity and Neurodevelopment
The Pennsylvania State University
218 Health and Human Development Building
University Park, PA 16802
814-865-7377
And
Director, National Prevention Science Coalition to Improve Lives
www.npscoalition.org

From: Bobby Vassar [mailto (b)(6)
Sent: Thursday, February 22, 2018 12:25 PM
To: DIANA H FISHBEIN <dfishbein@psu.edu>; roman-john@norc.org; Michael Greene (b)(6)
Subject: Gun violence research by the government hasn't been funded in two decades. But that may soon change.

This seems encouraging!

From: The Washington Post [mailto:email@washingtonpost.com]
Sent: Thursday, February 22, 2018 9:32 AM
To: Bobby Vassar
Subject: The Health 202: Gun violence research by the government hasn't been funded in two decades. But that may soon change.

Analysis on Washington's health-care debate. Not on the list? Sign up here.

PowerPost

The Health 20

Your health policy appointment

Share Share Tips/Feedback

Gun violence research by the government hasn't be two decades. But that may soon change.



BY PAIGE WINFIELD CUNNINGHAM
with Paulina Firozi

THE PROGNOSIS



CNN's town hall on gun violence, annotated

Is the latest school shooting enough to convince Congress to s violence research again? Democrats are hoping it just might be

In the wake of the Parkland, Fla., tragedy that left 17 dead at a local Republicans are generally resisting passing stricter gun control laws of their resolve is starting to crack as President Trump and GOP law an openness to strengthening background checks or gun violence r laws. One of them is Sen. Marco Rubio (R-Fla.), who participated in and emotional CNN town hall last night on gun violence in which he the minimum age for buying a rifle and stated he is reconsidering his capacity magazines.

And student displays — such as thelie-in protests teenagers staged White House this week – have given gun-safety advocates fresh ho

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AHH, OOF, OUCH



Fake Percocet pills that are actually fentanyl. (Tommy Farmer/Tennessee Bureau of Investigation via AP)

AHH: Drug overdose deaths declined in 14 states in the 12-month period before July 2017, according to new provisional

data from CDC reported by Stateline. While drug deaths have been climbing steadily every year, in nearly every state, the new data is a potentially hopeful sign that policies aimed at the opioid epidemic may be working, Christine Vestal writes.

"The reported drop in overdose deaths occurred in Wyoming, Utah, Washington, Alaska, Montana, Mississippi, Kansas, Rhode Island, Oregon, California, Tennessee, Massachusetts, Arizona and Hawaii," Christine writes. "That compares with declines in only three states — Nebraska, Washington and Wyoming — reported for an earlier 12-month period that ended in January 2017....Previously, the CDC only made death data available once a year and it was 12 to 14 months behind. **In a fast-moving opioid scourge, epidemiologists say the increased frequency of overdose death reporting is a welcome improvement."**



A resident of the Puerto Nuevo neighborhood in San Juan, Puerto Rico walks through flood water during the passage of Hurricane Maria. (HECTOR RETAMAL/AFP/Getty Images)

OOF: Calls to suicide hotlines in Puerto Rico have almost tripled in the months since Hurricane Maria. Starting in November and lasting through January, a crisis hotline on the island received 3,050 calls from people who said they had attempted suicide, a 246 percent increase compared with the same period last year, Vox's Alexia Fernandez Campbell reports. Even more people -- about 9,645 -- called the hotline to report suicidal thoughts, an 83 percent jump from the same time last year.

The suicide rate is the highest it has been in four years, Alexia writes, citing data reported by Puerto Rico's Department of Health and El Nuevo Día, Puerto Rico's largest newspaper. "It's hard to tell how much of the spike is directly related to the aftermath of Hurricane Maria. But the likely connection is difficult to ignore,"

Alexia writes.

Julio Santana Mariño, a psychology professor at Universidad Carlos Albizu in Puerto Rico, told El Nuevo Día the common risk factors for suicide were compounded in the aftermath of the storm. "It's normal for there to be family conflicts, but when you add the stress of more than five months without power, without food, living patterns change ... it makes it harder for people to manage daily life," Santana Mariño said.



The Duck Valley Indian Reservation in Owyhee, Nevada. (Darin Oswald for The Washington Post)

OUCH: Robert Weaver, Trump's nominee to lead the Indian Health Service, has withdrawn his name from consideration after a series of Wall Street Journal articles reporting that he'd embellished some of his previous professional experience and

left a former employer in financial disarray. "Mr. Weaver is no longer the Administration's nominee for Director of the Indian Health Service," an HHS spokeswoman told WSJ yesterday.

The paper reported that while Weaver said he maintained leadership positions at a hospital, former colleagues and supervisors claimed he served as a registration clerk. Weaver, who is a member of the Quapaw tribe, was nominated for the position in October.

TRUMP TEMPERATURE



President Trump. (AP Photo/Manuel Balce Ceneta)

--Trump has been prodding Congress to pass a "Right to Try"

law making experimental medications available to terminally ill patients, CNBC reports. A lawmaker working closely on the issue said last week the president asked him point blank, "How close are you to getting this done?"

A top priority for a number of conservative groups, Trump called for a Right to Try law in his State of the Union address last month. These laws, which 38 states have enacted, allow patients to take experimental medications outside of clinical trials as long as the therapies have undergone preliminary safety testing. Here's our Health 202 on Right to Try.



STATE SCAN



New Jersey Gov. Phil Murphy (D) signs legislation Wednesday setting aside about $7.5 million for family planning and women's health. (AP Photo/Michael Catalini)

--Yesterday New Jersey Gov. Phil Murphy, a Democrat, signed his first law in office, restoring $7.5 million for women's health and family planning that was vetoed by former Republican Gov. Chris Christie. "Today we are saying in a clear voice that New Jersey will once again stand for the right things," Murphy told a crowd that included Planned Parenthood President Cecile Richards, per the Associated Press. "New Jersey will once again stand up for women's health."

The funding, which Christie slashed eight years ago, went to health providers, including Planned Parenthood, but couldn't be used for abortions. **While Christie said he opposed the legislation**

because it circumvented the regular budget process, Democrats who control the state legislature said it's needed for preventive care, including breast and cervical cancer screenings.

"The eight-year wait to restore the funding was a pointed theme," the AP writes. "Murphy thanked a host of lawmakers for passing the legislation and focused at one point on sponsor Senate Majority Leader Loretta Weinberg, who introduced the bill each year of Christie's term."

"If there's a motto that we can ascribe to you I think it is this: If at first you don't succeed try, try, try and try, try, try and try and try again," he said.

--A few more good reads from The Post and beyond:

Florida House Declines Debate On Assault Rifles, Calls Porn A 'Health Risk'



The lawmakers voted 71-36 against opening up debate on the bill that would ban assault weapons and large-capacity magazines, leaving it in committees that aren't scheduled to meet during this session.

NPR • Read more »

HEALTH ON THE HILL

Beyond 'Obamacare': New liberal plan on health care overhaul



A major liberal policy group is raising the ante on the health care debate with a new plan that builds on Medicare to guarantee coverage for all. Called "Medicare Extra for All," the proposal to be released Thursday by the Center for American Progress gives politically energized Democrats more options to achieve a long-sought goal.
Associated Press • Read more »

MEDICAL MISSIVES

It's OK to Use Nasal Spray Flu Vaccine Again, US Panel Says



It's OK for doctors to start using a kid-friendly nasal spray flu vaccine again, a federal panel said Wednesday.
Associated Press • Read more »

Study Seeks to End Antidepressant Debate-The Drugs Do Work



A vast research study that sought to settle a long-standing debate about whether or not anti-depressant drugs really work has found they are indeed effective in relieving acute depression in adults.
Reuters • Read more »

OPIOID OPTICS

Mexican cartels pushing more heroin after U.S. states relax marijuana laws

Mexican growers and cartels find trafficking heroin more profitable than marijuana as some states allow marijuana use.

USA Today • Read more »



DAYBOOK

Coming Up

- The Joint House and Senate Veterans' Affairs Committees hold a hearing on the legislative presentation of the Disabled American Veterans on **March 1.**

SUGAR RUSH

Unpacking America's perceptions about mass shootings and gun control:



Unpacking America's perceptions about mass shootings and gun control

Trump’s meeting with Florida school shooting survivors, in three minutes:



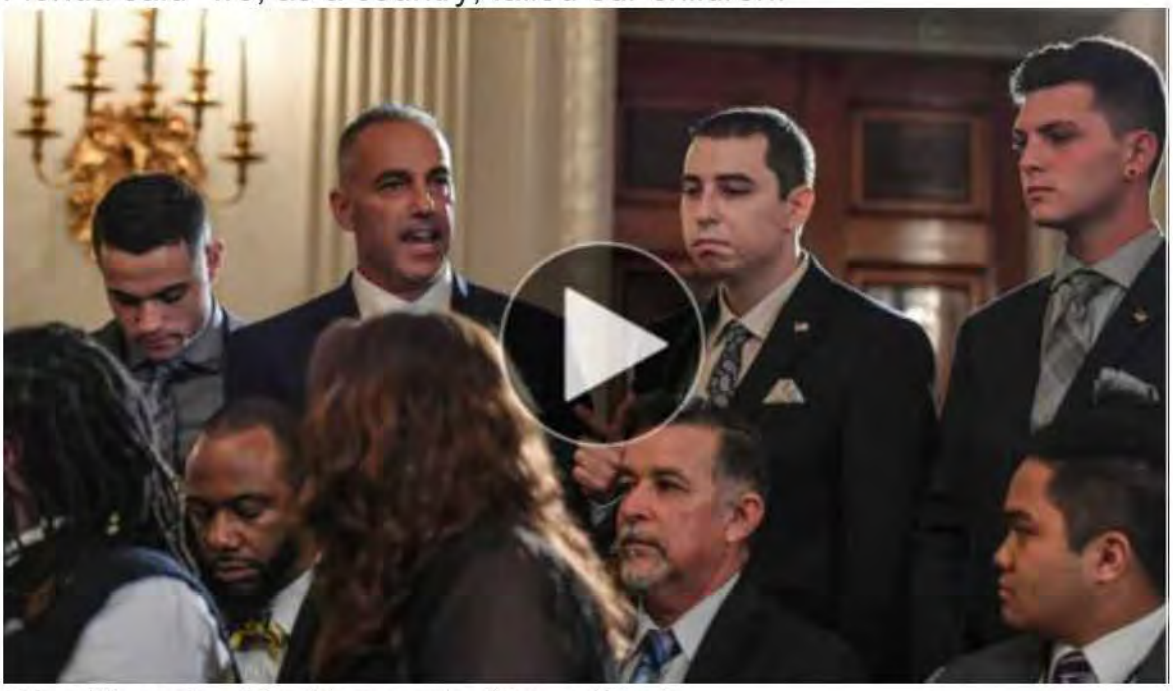
Trump’s meeting with Fla. school shooting survivors, in three minutes

Fred Guttenberg, whose daughter Jaime was killed in last week's shooting, called Sen. Marco Rubio's (R-Fla.) comments at a CNN town hall "pathetically weak:"



Parent of Fla. shooting victim slams Rubio for 'pathetically weak' comments

Andrew Pollack, whose daughter died in the high school shooting in Florida said “we, as a country, failed our children:"



Father of Fla. shooting victim: ‘We, as a country, failed our children’

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The Washington Post

Democracy Dies in Darkness

^ =X!L

Bobby

"The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little." **FDR, 1933**

From: Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Sent: 17 Mar 2016 19:08:42 -0400
To: Bonzo, Sandra E. (CDC/ONDIEH/OD);Houry, Debra E. (CDC/ONDIEH/NCIPC)
Cc: Ikeda, Robin (CDC/ONDIEH/OD)
Subject: Re: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Interesting indeed!

Thank you!
Amy
404-259-6787

From: Bonzo, Sandra E. (CDC/ONDIEH/OD)
Sent: Thursday, March 17, 2016 12:05 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC); Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Cc: Ikeda, Robin (CDC/ONDIEH/OD)
Subject: FW: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

---

May be a coincidence but compare questions in the attached letter to the questions from Kate Masters in early February.

From: Jones, Kamara (OS/ASPA)
Sent: Tuesday, March 15, 2016 4:00 PM
To: Robinson, Michael J (HHS/ASPA) <michael.robinson@hhs.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; OS - Interviews <interviews@hhs.gov>; Beeton, Jonathan (OS/OASH) <Jonathan.Beeton@hhs.gov>; Broido, Tara (HHS/OASH) <Tara.Broido@hhs.gov>; Gianelli, Diane M (OASH) <Diane.Gianelli@hhs.gov>; Migliaccio, Kate (HHS/OASH) <Kate.Migliaccio@hhs.gov>
Cc: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Bryant, LaKia R. (CDC/OD/OADC) <vuf3@cdc.gov>
Subject: RE: CDC Interview (email) request from The Trace: gun violence DEADLINE: 03-14-16
Do we know the exact date when the piece will be published?
From: Robinson, Michael J (HHS/ASPA)
Sent: Monday, March 14, 2016 6:01 PM
To: Burden, Bernadette (CDC/OD/OADC); OS - Interviews; Beeton, Jonathan (OS/OASH); Broido, Tara (HHS/OASH); Gianelli, Diane M (OASH); Migliaccio, Kate (HHS/OASH)
Cc: Lenard, Courtney (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Bryant, LaKia R. (CDC/OD/OADC)
Subject: Re: CDC Interview (email) request from The Trace: gun violence DEADLINE: 03-14-16
Ok

From: Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>
Sent: Monday, March 14, 2016 5:44:37 PM
To: OS - Interviews; Robinson, Michael J (HHS/ASPA)
Cc: Lenard, Courtney (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Bryant, LaKia R.

(CDC/OD/OADC)

Subject: FW: CDC Interview (email) request from The Trace: gun violence DEADLINE: 03-14-16

****

ASPA Media Interview Request Template

****

Reporter: Kate Masters
Organization: The Trace
Phone #(s):
Subject: gun violence
Deadline: 03-14-16
Spokesperson: N/A emailed response only.

Kate Masters with The Trace has a follow up, please see her several previous requests in the thread below in addition the proposed CDC response. Her deadline is today.

From Kate:

Thanks again for all the information about the NVDRS. It was definitely helpful and that piece should be up on our site soon. I'm emailing today because my editors and I are in the drafting phase of my piece on gun violence research at the CDC, and I wanted to let you know that the basis of the story is that the CDC is avoiding the issue of gun violence and bowing to political pressure by essentially foregoing research on firearms, even though there are things the agency could be doing. This is coming from former employees of the CDC, as well as outside gun violence researchers.

I wanted to tell you this so there would be no surprise when the article came out, and also because I wanted to give the CDC a chance to respond to what others are saying. That response could be a statement from you, or I would still love to speak with Dr. Houry directly about the lack of gun research at the Injury Center, but I do recommend addressing these statements somehow so that the CDC's voice is included in the piece.

Proposed Response:

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States.

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

The President has requested that CDC conduct research into the causes and prevention of gun violence and the IOM Report noted a number of research areas that might have bipartisan support. CDC is ready to conduct that research if funds are appropriated by Congress.

Thanks in advance,
Bernadette Burden

Senior Public Affairs Specialist
News Media Branch
Division of Public Affairs
CDC/ATSDR
(404)639-3286

From: Robinson, Michael J (HHS/ASPA)
Sent: Friday, February 12, 2016 11:22 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Blackmore, Rebecca (HHS/ASFR) <Rebecca.Blackmore@hhs.gov>; Medvedev, Bree (OS/ASFR) <Bree.Medvedev@hhs.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>; Beeton, Jonathan (OS/OASH) <Jonathan.Beeton@hhs.gov>; Broido, Tara (HHS/OASH) <Tara.Broido@hhs.gov>; Colson, Angela (HHS/OASH) <Angela.Colson@hhs.gov>; Gianelli, Diane M (OASH) <Diane.Gianelli@hhs.gov>; Migliaccio, Kate (HHS/OASH) <Kate.Migliaccio@hhs.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Fine, Amanda (NIH/OD) [E] <amanda.fine@nih.gov>
Subject: RE: CDC Interview (email) request from The Trace: gun violence

Ok

From: Lenard, Courtney (CDC/ONDIEH/NCIPC) [mailto:zvq5@cdc.gov]
Sent: Friday, February 12, 2016 11:16 AM
To: Robinson, Michael J (HHS/ASPA); Blackmore, Rebecca (HHS/ASFR); Medvedev, Bree (OS/ASFR); Cabezas, Miriam (HHS/ASFR); Beeton, Jonathan (OS/OASH); Broido, Tara (HHS/OASH); Colson, Angela (HHS/OASH); Gianelli, Diane M (OASH); Migliaccio, Kate (HHS/OASH); Cabezas, Miriam (HHS/ASFR)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Dorigo, Leslie (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Burden, Bernadette (CDC/OD/OADC); Fine, Amanda (NIH/OD) [E]
Subject: RE: CDC Interview (email) request from The Trace: gun violence

Good morning,
Deadline is COB today.
Thank you!
Courtney

From: Robinson, Michael J (HHS/ASPA)
Sent: Thursday, February 11, 2016 4:50 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Blackmore, Rebecca (HHS/ASFR) <Rebecca.Blackmore@hhs.gov>; Medvedev, Bree (OS/ASFR) <Bree.Medvedev@hhs.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>; Beeton, Jonathan (OS/OASH) <Jonathan.Beeton@hhs.gov>; Broido, Tara (HHS/OASH) <Tara.Broido@hhs.gov>; Colson, Angela (HHS/OASH) <Angela.Colson@hhs.gov>; Gianelli, Diane M (OASH) <Diane.Gianelli@hhs.gov>; Migliaccio, Kate (HHS/OASH) <Kate.Migliaccio@hhs.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Fine, Amanda (NIH/OD) [E] <amanda.fine@nih.gov>
Subject: RE: CDC Interview (email) request from The Trace: gun violence

Hi –Adding ASFR
What's the deadline for this info?

Best,

From: Lenard, Courtney (CDC/ONDIEH/NCIPC) [mailto:zvq5@cdc.gov]
Sent: Thursday, February 11, 2016 4:48 PM
To: Robinson, Michael J (HHS/ASPA); OS - Interviews; Cabezas, Miriam (HHS/ASFR); Beeton, Jonathan (OS/OASH); Broido, Tara (HHS/OASH); Colson, Angela (HHS/OASH); Gianelli, Diane M (OASH); Migliaccio, Kate (HHS/OASH)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Dorigo, Leslie (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Burden, Bernadette (CDC/OD/OADC); Fine, Amanda (NIH/OD) [E]
Subject: RE: CDC Interview (email) request from The Trace: gun violence

Good afternoon,

Another follow up from Kate with The Trace:

I also know that the President requested the full $23.5 million required to place NVDRS in all 50 states and the District of Columbia in his FY2017 budget request. I asked the White House why that decision was made and why the NVDRS was prioritized this year, and they told me to check with the CDC. So do you guys have any information on why that request was made and why it was important to the administration?

Proposed Response:

The President's budget request for NVDRS has been for $23.5m for several years (since the FY14 request). Expansion of NVDRS to all 50 states and DC has been a priority for the administration since FY14. Although CDC has seen incremental increases (including most recently in FY 16) and will be able to expand the program this year, the FY17 request will allow CDC to expand the program further to truly have a national program (all 50 states and DC).

*NVDRS is the only state-based surveillance system that pools information from multiple data sources into a usable, anonymous data base. It covers all types of violent deaths – including homicides, suicides, and child maltreatment fatalities – in all settings and for all age groups.

Thanks much!

Courtney

From: Robinson, Michael J (HHS/ASPA)
Sent: Thursday, February 04, 2016 4:21 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; OS - Interviews <interviews@hhs.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>; Beeton, Jonathan (OS/OASH) <Jonathan.Beeton@hhs.gov>; Broido, Tara (HHS/OASH) <Tara.Broido@hhs.gov>; Colson, Angela (HHS/OASH) <Angela.Colson@hhs.gov>; Gianelli, Diane M (OASH) <Diane.Gianelli@hhs.gov>; Migliaccio, Kate (HHS/OASH) <Kate.Migliaccio@hhs.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Fine, Amanda (NIH/OD) [E] <amanda.fine@nih.gov>
Subject: RE: CDC Interview (email) request from The Trace: gun violence

Ok

From: Lenard, Courtney (CDC/ONDIEH/NCIPC) [mailto:zvq5@cdc.gov]
Sent: Thursday, February 04, 2016 4:19 PM
To: Robinson, Michael J (HHS/ASPA); OS - Interviews; Cabezas, Miriam (HHS/ASFR); Beeton, Jonathan (OS/OASH); Broido, Tara (HHS/OASH); Colson, Angela (HHS/OASH); Gianelli, Diane M (OASH); Migliaccio, Kate (HHS/OASH)
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Dorigo, Leslie (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Burden, Bernadette (CDC/OD/OADC); Fine,

Amanda (NIH/OD) [E]
Subject: RE: CDC Interview (email) request from The Trace: gun violence
Good afternoon,
We have a follow up from Kate:
does the CDC still have a "gentleman's agreement" with the gun lobby to report out, to the lobby, any gun research completed by their grantees, whether that research was actually completed with CDC funds or not?
Proposed response, this question came up in the AP interview from a few months ago and this is what we said:
We routinely alert stakeholder organizations when relevant articles are released, including organizations such as the NRA, who are interested in firearm related violence. We have not reached out to the NRA in recent years.
Thanks much!
Courtney
From: Robinson, Michael J (HHS/ASPA)
Sent: Wednesday, February 03, 2016 1:27 PM
To: OS - Interviews <interviews@hhs.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Cabezas, Miriam (HHS/ASFR) <Miriam.Cabezas@hhs.gov>; Beeton, Jonathan (OS/OASH) <Jonathan.Beeton@hhs.gov>; Broido, Tara (HHS/OASH) <Tara.Broido@hhs.gov>; Colson, Angela (HHS/OASH) <Angela.Colson@hhs.gov>; Gianelli, Diane M (OASH) <Diane.Gianelli@hhs.gov>; Migliaccio, Kate (HHS/OASH) <Kate.Migliaccio@hhs.gov>
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC) <efd5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Fine, Amanda (NIH/OD) [E] <amanda.fine@nih.gov>
Subject: FW: CDC Interview (email) request from The Trace: gun violence
Ok
(#7 is new)
From: Lenard, Courtney (CDC/ONDIEH/NCIPC) [mailto:zvq5@cdc.gov]
Sent: Wednesday, February 03, 2016 1:05 PM
To: OS - Interviews
Cc: Connelly, Erin (CDC/ONDIEH/NCIPC); Dorigo, Leslie (CDC/ONDIEH/NCIPC); Lane, Gabraelle (CDC/ONDIEH/NCIPC); Harben, Kathy (CDC/OD/OADC); Burden, Bernadette (CDC/OD/OADC); Fine, Amanda (NIH/OD) [E]
Subject: CDC Interview (email) request from The Trace: gun violence
ASPA Media Interview Request
****
Outlet: The Trace
Reporter: Kate Masters
Phone: (571) 643-4275
Subject: gun violence research
Deadline: today
Spokesperson: **email response attributed to Deb Houry**, MD, MPH, director, CDC's Injury Center
Expected place of publication (print, online, broadcast): print
Expected date of publication/airing: n/a
Expected prominence (e.g. front page, Sunday, evening/morning show, etc.): n/a
Background:

FROM KATE: She requested to interview Deb Houry. *"My article is going to be about violence research at the CDC versus the NIH, so most of my questions would center on her approach to running the Center for Injury Control and Prevention, accomplishments she's made, and priorities she'd still like to work on."*

Actual questions:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?
2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?
3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?
4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?
5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?
6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?
7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?
8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

PROPOSED RESPONSE:

1. Do you feel that the Injury Center would still suffer consequences from Congress for doing any type of gun violence research, even though there's growing political pressure to repeal the Dickey Amendment and allow the CDC to resume research on firearms? And if so, why?

There is not appropriations language that prohibits CDC from conducting public health research into gun violence.

2. I know that Congress has repeatedly refused to allocate funding specifically for gun violence research, but would it be feasible for the CDC to reallocate some of its overall budget to go to gun research?

The Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention. CDC currently conducts and funds research on a variety of related topics, including youth violence, child maltreatment, domestic violence and sexual violence. These are the topical line items that are supported through CDC's annual appropriation for both research and non-research activities. However, firearms

are a mechanism of injury, so it is possible to address firearm-related violence in the context of addressing these topical areas and preventing violence from occurring in the first place.

3. In 2013, the NIH announced a new funding program that called specifically for research projects on gun violence. How was the NIH able to do that, given that it's also subject to federal limitations on gun research? And what's stopping the CDC from doing something similar?

Beginning in FY 1997, CDC has been subject to appropriations language that states that none of the funds made available to CDC may be used to "advocate or promote gun control." Similar appropriations language was extended to all HHS agencies, including NIH, beginning in FY 2012. The appropriations language does not prohibit the CDC or the NIH from conducting public health research into gun violence. CDC limited its research on gun violence over time, not because it was legally prohibited, but rather, because in 1997 Congress cut CDC's budget by an amount equal to what had been spent on research into gun violence (about $2.7 million at the time) and threatened to impose further cuts if that research continued. Should we receive appropriations, we are ready to support research in this area in line with IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence –.*

4. The Dickey Amendment doesn't technically ban gun violence research, so are there any projects or research on gun violence that the CDC could be doing without violating the language of the amendment?

CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. As noted above, the Injury Center has very limited discretionary funding to dedicate to firearm violence research and prevention.

5. Whatever happened to the 2013 research agenda on gun violence that the CDC commissioned from the Institute of Medicine? Have any of those research goals been addressed? If not, why commission a research agenda if there was no intention to use it?

The IOM/NRC research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – was released by the IOM/NRC on June 5, 2013. It was intended to guide research in the field and has been referenced in various funding solicitations by other agencies. Individual researchers may also be pursuing some of the research priorities on their own. Every year since the release of *Now is the Time*, President Obama has included a $10 million request in his budget to research the causes and prevention of gun violence, but Congress has not approved it. To pursue many of the research priorities that IOM and NRC identified, this $10 million would be necessary.

6. Do you feel that the Injury Center should be researching guns and gun violence, that it falls under the jurisdiction of the agency?

More than 117,000 Americans are non-fatally injured or die each year from a gunshot wound, making firearm-related injuries among the 5 leading causes of death for people aged 1-64 in the United States. Public health research is fundamental to understanding

the problem and developing scientifically sound solutions. As noted by the IOM/NRC, "The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be incorporated into the strategies used to prevent future harm and injuries."

7. Has the CDC dedicated any funding to research involving guns or gun violence since the Dickey Amendment was passed? If so, how much money would you say goes toward that kind of research per year?

Following the FY 1997 appropriation language, CDC-funded entities conducted some investigator-initiated, peer-reviewed studies on fatal and non-fatal firearm violence through the Injury Control and Response Centers (ICRCs), the first cycle of the Academic Centers for Excellence on Youth Violence Prevention (ACEs), and universities awarded R01 (investigator-initiated) grants. Some of these projects began before FY 1997 and continued throughout their funding period.

Examples:

- one study (which began in 1995) examined the risk factors for gun use and gun injury among young males in neighborhoods with high rates of homicide and determined the characteristics and processes of interpersonal interactions where gun injuries occur compared to non-gun injuries.
- A 1998 study examined the effectiveness of household firearm storage methods in reducing unintentional and self-inflicted firearm injuries among children and adolescents;
- A 1999 study examined the risks for retaliatory shootings and the role of gangs, drugs, and alcohol to inform future opportunities for prevention;
- A longitudinal study initiated in 2001 examined intentional injury among urban youth, which included questions regarding gun carrying and reasons for gun carrying; and

CDC has also published a number of papers and reports. Examples listed below.

8. Did the CDC stop monitoring U.S. gun ownership in 2004, and why?

The Behavioral Risk Factor Surveillance System (BRFSS) does not currently collect data about firearms. Firearms questions were included as optional modules for states to consider between 1995-1999 and a subset of questions were included on the core survey in 2001, 2002, and 2004. In 2004, the BRFSS state coordinators decided to retain only the question on seat belts in the survey and dropped the other injury-related topics from the survey. The injury questions had been on the survey for a number of years and there was interest at the time in pursuing other public health topics. Each year, BRFSS coordinators from state and territorial health departments decide which questions to include on the BRFSS questionnaire. CDC supports this development and works with the state coordinators to balance state and federal public health needs in an effort to ensure a standardized, valid, and reliable questionnaire and data collection process. Also, state health departments can decide to include additional questions. Firearm safety questions are currently under consideration for future BRFSS surveys. For more information about BRFSS, please visit: www.cdc.gov/brfss.

***ARTICLES**

Firearm injuries in the United States

Prev Med. 2015 Oct;79:5-14
http://www.ncbi.nlm.nih.gov/pubmed/26116133
Firearm Homicides and Suicides in Major Metropolitan Areas — United States, 2006–2007 and 2009–2010
MMWR. August 2, 2013 / 62(30);597-602
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6230a1.htm
Violence in the United States: Status, Challenges, and Opportunities
JAMA. 2015;315(5):478-488
Attached
Suicide Trends Among Persons Aged 10–24 Years — United States, 1994–2012
MMWR. March 6, 2015 / 64(08);201-205
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm
Homicide Rates Among Persons Aged 10–24 Years — United States, 1981–2010
MMWR. July 12, 2013 / 62(27);545-548
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6227a1.htm
Gang Homicides — Five U.S. Cities, 2003–2008
MMWR. January 27, 2012 / 61(03);46-51
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a2.htm
Most recent NVDRS Surveillance Summary:
Surveillance for Violent Deaths — National Violent Death Reporting System, 16 States, 2010
MMWR. January 17, 2014 / 63(SS01);1-33
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, March 16, 2016 2:18 PM
To: Ikeda, Robin (CDC/ONDIEH/OD) ; Bonzo, Sandra E. (CDC/ONDIEH/OD)
Cc: Peeples, Amy B. (CDC/ONDIEH/NCIPC)
Subject: FW: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

Fyi- received today
Opp will begin working on it
Deb Houry, MD, MPH
Director
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
4770 Buford Highway, NE; Mail Stop F63; Atlanta, GA 30341
Twitter: @DebHouryCDC
Phone: (770) 488-4696 || Fax: (770) 488-4222

From: Morris, Dena (CDC/OD/CDCWO)
Sent: Wednesday, March 16, 2016 1:59 PM
To: Frieden, Thomas (Tom) (CDC/OD) <txf2@cdc.gov>; Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Berger, Sherri (CDC/OCOO/OD) <sob8@cdc.gov>; Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>
Subject: Letter from Senate HSGAC Ranking Member Carper regarding gun violence research

For your awareness.

From: Patterson, Sara S. (CDC/ONDIEH/NCIPC)
Sent: 6 Apr 2016 08:44:10 -0400
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC);Houry, Debra E. (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC);Connelly, Erin (CDC/ONDIEH/NCIPC);Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Lenard, Courtney (CDC/ONDIEH/NCIPC);Reimels, Elizabeth (CDC/ONDIEH/NCIPC);Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC);Burton, Tessa (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Over 100 orgs sign letter to Congress re: CDC/gun research
Attachments: 160404_Gun Violence Letter to Congress.pdf

Also, attached is a letter from Richard Carmona (former SG) to House/Senate leadership…

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 06, 2016 8:08 AM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) ; Peeples, Amy B. (CDC/ONDIEH/NCIPC) ; Connelly, Erin (CDC/ONDIEH/NCIPC) ; Patterson, Sara S. (CDC/ONDIEH/NCIPC) ; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) ; Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) ; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) ; Burton, Tessa (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: Over 100 orgs sign letter to Congress re: CDC/gun research
Importance: High

Not sure who all is around this week or checking BB while out, but wanted to share this around…

Public health groups urge Congress to allow funding of gun control research

Nearly 150 public health organizations — including heavy hitters like the American Medical Association, Doctors for America, and AAAS — have sent a letter to Congress this morning urging lawmakers to end restrictions on gun violence research. The CDC has been banned from funding research that might promote gun control since 1996.

http://files.www.drsforamerica.org/blog/blogs-from-dc-climate-change-and-health-at-the-white-house/CDC_letter_4-6_FINAL.pdf

Full letter attached/at link, and pasted below for those on BB.

April 6, 2016

The Honorable Thad Cochran

Chairman, Appropriations Committee

U.S. Senate

Washington, DC 20515

The Honorable Barbara Mikulski

Vice Chairwoman, Appropriations Committee

U.S. Senate

Washington, DC 20515

The Honorable Harold Rogers

Chairman, Appropriations Committee

U.S. House of Representatives

Washington, DC 20515

The Honorable Nita Lowey

Ranking Member, Appropriations Committee

U.S. House of Representatives

Washington, DC 20515

Dear Senator/Representative:

The undersigned health care, public health, scientific organizations and research universities representing over 1 million members across the country **urge you to end the dramatic chilling effect of the current rider language restricting gun violence research and to fund this critical work at the Centers for Disease Control and Prevention (CDC).**

In 1996, Congress passed the so-called Dickey amendment as a rider to the Labor-Health and Human Services-Education Appropriations bill. The language stated that the CDC could not fund research that would "advocate or promote gun control," and the language has remained in each subsequent annual funding bill. At the same time, Congress cut CDC funding for this research. Although the Dickey amendment does not explicitly prevent research on gun violence, the combination of these two actions has caused a dramatic chilling effect on federal research that has stalled and stymied progress on gathering critical data to inform prevention of gun violence for the past 20 years. Furthermore, it has discouraged the next generation of researchers from entering the field.

Gun violence is a serious public health epidemic resulting in the senseless deaths of an average of 91 Americans, and another 108 gun injuries, each and every day. A central part of preventing future tragedies is through conducting rigorous scientific research as this has been a proven successful approach in reducing deaths due to other injuries.

Health care providers and public health professionals are overwhelmed in emergency departments, clinics, offices, and communities with the victims of mass shootings, homicides, suicides, accidental shootings, and firearm injuries. Medical professionals and our communities work to address the devastating and long-lasting physical and emotional effects of gun violence on victims, their families and their friends, but are hampered by the insufficient body of evidence-based research to use to point communities toward proven gun violence prevention programs and policies.

Former Representative Jay Dickey (R-AR), author of the current language that has effectively restricted gun violence research, recently noted that, "it is my position that somehow or someway we should slowly but methodically fund [gun] research until a solution is reached. Doing nothing is no longer an acceptable solution."

Here are some of the critical questions that enhanced research would help us answer:

1) **What is the best way to protect toddlers from accidentally firing a firearm?** Safe firearm storage works, but what kinds of campaigns best encourage safe storage? What safe storage methods are the most effective and most likely to be adopted? What should be the trigger pull on a firearm so a toddler can't use it?

2) **What are the most effective ways to prevent gun-related suicides?** Two-thirds of firearm related deaths are suicides. Are firearm suicides more spontaneous than non-firearm suicides? Do other risk factors vary by method? How do we prevent it in different populations—active military, veterans, those with mental illness, law enforcement or correctional officers, the elderly, or teenagers?

3) **What is the impact of the variety of state policies being enacted?** How are different policies around safe storage, mental health, public education, and background checks impacting firearm injuries and deaths?

The CDC's National Center for Injury Prevention and Control is an important part of answering these types of questions. Public health uniquely brings together a comprehensive approach connecting the complex factors that result in violence and injuries including clinical, social, criminal, mental health, and environmental factors.

The impact of federal public health research in reducing deaths from car accidents, smoking and Sudden Infant Death Syndrome has been well proven. Decades ago, we did not know infant car seats should be rear-facing. Robust research on car accidents and subsequent legislation has helped save hundreds of thousands of lives without preventing people from being able to drive. It's time to apply the same approach to reducing gun violence in our communities.

As professionals dedicated to the health of the nation and to the application of sound science to improving the lives of our fellow Americans, we urge you to take action this year. Americans deserve to know that we are working with the best tools and information in the fight to reduce gun violence deaths and injuries.

As Congress works to craft the FY 2017 Labor-HHS-Education Appropriations bill, we urge you to provide the Centers for Disease Control and Prevention with funding for research into the causes and prevention of gun violence.

Thank you for your consideration. We look forward to working with you to improve health and protect the safety of all Americans.

Sincerely,

Academic Consortium for Integrative Medicine & Health Academic Pediatric Association Alameda Health System Department of Emergency Medicine American Academy of Family Physicians American Academy of Pediatrics American Association for the Advancement of Science American Association of Colleges of Pharmacy American Association of Nurse Practitioners American College of Emergency Physicians American College of Emergency Physicians, California Chapter American College of Occupational and Environmental

Medicine American College of Physicians American Congress of Obstetricians and Gynecologists American Educational Research Association American Geriatrics Society American Medical Association American Medical Student Association American Medical Women's Association American Pediatric Society American Psychiatric Association American Psychological Association American Public Health Association American Society for Clinical Pathology American Society of Hematology American Thoracic Society American Trauma Society Arkansas Public Health Association Asociación de Salud Pública de Puerto Rico Association for Psychological Science Association of American Universities Association of Medical School Pediatric Department Chairs Association of Population Centers Association of Public and Land-grant Universities Big Cities Health Coalition Boulder County Public Health Brigham Psychiatric Specialties California Center for Public Health Advocacy California Public Health Association-North Center for Science and Democracy at the Union of Concerned Scientists Central Oregon Medical Society Champaign-Urbana Public Health District Chicago Center for Psychoanalysis Chicago chapter Physicians for Social Responsibility Colorado Public Health Association Committee of Interns and Residents/SEIU Healthcare Congregation Gates of Heaven

Consortium of Social Science Associations Council of State and Territorial Epidemiologists Cure Violence Delaware Academy of Medicine / Delaware Public Health Association Doctors Council SEIU Doctors for America Eastern Association for the Surgery of Trauma Federation of Associations in Behavioral and Brain Sciences Florida Chapter of the American Academy of Pediatrics, Inc. Futures Without Violence Georgia Public Health Association Hawaii Public Health Association Health Officers Association of California Houston Health Department Illinois Public Health Association International Society for Developmental Psychobiology Iowa Chapter Physicians for Social Responsibility Iowa Public Health Association JPS Health Network Kansas Public Health Association Koop Institute KU Department of Preventive Medicine and Public Health Law and Society Association Lee County Health Department Local Public Health Association of Minnesota Louisiana Center for Health Equity Maine Public Health Association Maryland Academy of Family Physicians Minnesota Public Health Association Montana Public Health Association National AHEC Organization National Association of County and City Health Officials National Association of Medical Examiners National Association of Nurse Practitioners in Women's Health National Association of Social Workers National Association of State Emergency Medical Services Officials National Association of State Head Injury Administrators National Black Nurses Association National Hispanic Medical Association National Medical Association National Network of Public Health Institutes National Physicians Alliance National Violence Prevention Network Nevada Public Health Association

New Hampshire Public Health Association New Mexico Public Health Association North Carolina Public Health Association Ohio Public Health Association Ohio Public Health Association Oregon Academy of Family Physicians Oregon Physicians for Social Responsibility Oregon Public Health Association Pediatric Policy Council Physicians for Social Responsibility, Arizona Chapter Physicians for a National Health Program NY Metro Chapter Physicians for Reproductive Health Physicians for Social Responsibility / Northeast Ohio Physicians for Social Responsibility Wisconsin Physicians for Social Responsibility, Arizona Chapter Physicians for Social Responsibility/New York Physicians for the Prevention of Gun Violence Population Association of America Prevention Institute Psychonomic Society Public Health Association of Nebraska Public Health Association of New York City Public Health Institute Research!America RiverStone Health Safe States Alliance San Francisco Bay Area Chapter, Physicians for Social Responsibility Society for Adolescent Health and Medicine Society for Advancement of Violence and Injury Research Society for Mathematical Psychology Society for Pediatric Research Society for Psychophysiological Research Society for Public Health Education Society of Experimental Social Psychology Society of General Internal Medicine Southern California Public Health Association Southwest Ohio Society of Family Medicine Student National Medical Association Suicide Awareness Voices of Education Texas Doctors for Social Responsibility Texas Public Health Association Trauma Foundation Tri-County Health Department Trust for America's Health

United Physicians of Newtown Vermont Public Health Association Virginia Public Health Association Washington Chapter of the American Academy of Pediatrics Washington State Public Health Association Wellness Institute of Greater Buffalo Whiteside County Health Department

cc:

The Honorable Mitch McConnell

The Honorable Paul Ryan

The Honorable Harry Reid

The Honorable Nancy Pelosi Members of Congress

RICHARD H. CARMONA, M.D., M.P.H., FACS
17th Surgeon General of the United States

April 4, 2016

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Harry Reid
Minority Leader
U. S Senate
Washington, DC 20510

The Honorable Paul Ryan
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Nancy Pelosi
Democratic Leader
U.S. House of Representatives
Washington, DC 20515

Dear Majority Leader McConnell, Minority Leader Reid, Speaker Ryan, Leader Pelosi, and Members of the United States Senate and the U. S. House of Representatives:

As the former Surgeon General of the United States and as a police officer and U.S. Army Special Forces combat veteran, I write to you to urge Congress to encourage and fund research into firearms related violence in order to objectively be able to address the significant public health consequences of firearms related death and disability.

Currently a restrictive Congressional budget amendment passed in 1996 prevents federally funded gun violence research. Although the President has lifted the ban, Congress has not yet funded the research.

The morbidity, mortality and cost of firearms related death and disability in the United States constitutes a major public health challenge. The gun issue in the United States has become exceedingly politicized with each side arguing its position more on emotion rather than needed epidemiologic science.

As a soldier and police officer, I have owned and used firearms most of my life; as a citizen, I own firearms and I believe that fellow citizens who are appropriately educated in firearms safety and vetted for risk should be able to safely own firearms.

However, without appropriate research into firearms related death and disability, we really have no idea what policies and/or regulation may be needed in order to ensure the public's safety.

Our Center for Disease Control and Prevention has been a global leader in addressing all types of public health risk and discerning what risk factors need to be addressed, for any and all causes, in order to prevent death and disability and reduce the cost of care.

Vice Chairman
Canyon Ranch

President
Canyon Ranch Institute

Distinguished Professor
Zuckerman College of Public Health
University of Arizona

I respectfully urge you to consider funding this needed research through CDC and any other academic, public and private organizations that have the expertise to provide the unbiased scientific information to guide our nation's future decisions and ensure the public's health and safety.

Sincerely,

Richard H. Carmona, M.D., M.P.H., FACS

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: 6 Apr 2016 12:14:00 +0000
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Subject: Re: Over 100 orgs sign letter to Congress re: CDC/gun research

Thx

Sent from my BlackBerry 10 smartphone.
From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 6, 2016 8:08 AM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC); Peeples, Amy B. (CDC/ONDIEH/NCIPC); Connelly, Erin (CDC/ONDIEH/NCIPC); Patterson, Sara S. (CDC/ONDIEH/NCIPC); Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC); Lenard, Courtney (CDC/ONDIEH/NCIPC); Reimels, Elizabeth (CDC/ONDIEH/NCIPC); Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC); Burton, Tessa (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Dahlberg, Linda L. (CDC/ONDIEH/NCIPC); Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: Over 100 orgs sign letter to Congress re: CDC/gun research

Not sure who all is around this week or checking BB while out, but wanted to share this around…

Public health groups urge Congress to allow funding of gun control research

Nearly 150 public health organizations — including heavy hitters like the American Medical Association, Doctors for America, and AAAS — have sent a letter to Congress this morning urging lawmakers to end restrictions on gun violence research. The CDC has been banned from funding research that might promote gun control since 1996.
http://files.www.drsforamerica.org/blog/blogs-from-dc-climate-change-and-health-at-the-white-house/CDC_letter_4-6_FINAL.pdf
Full letter attached/at link, and pasted below for those on BB.
April 6, 2016

The Honorable Thad Cochran
Chairman, Appropriations Committee
U.S. Senate
Washington, DC 20515
The Honorable Barbara Mikulski
Vice Chairwoman, Appropriations Committee
U.S. Senate
Washington, DC 20515
The Honorable Harold Rogers
Chairman, Appropriations Committee
U.S. House of Representatives
Washington, DC 20515
The Honorable Nita Lowey
Ranking Member, Appropriations Committee
U.S. House of Representatives

Washington, DC 20515
Dear Senator/Representative:

The undersigned health care, public health, scientific organizations and research universities representing over 1 million members across the country **urge you to end the dramatic chilling effect of the current rider language restricting gun violence research and to fund this critical work at the Centers for Disease Control and Prevention (CDC).**

In 1996, Congress passed the so-called Dickey amendment as a rider to the Labor-Health and Human Services-Education Appropriations bill. The language stated that the CDC could not fund research that would "advocate or promote gun control," and the language has remained in each subsequent annual funding bill. At the same time, Congress cut CDC funding for this research. Although the Dickey amendment does not explicitly prevent research on gun violence, the combination of these two actions has caused a dramatic chilling effect on federal research that has stalled and stymied progress on gathering critical data to inform prevention of gun violence for the past 20 years. Furthermore, it has discouraged the next generation of researchers from entering the field.

Gun violence is a serious public health epidemic resulting in the senseless deaths of an average of 91 Americans, and another 108 gun injuries, each and every day. A central part of preventing future tragedies is through conducting rigorous scientific research as this has been a proven successful approach in reducing deaths due to other injuries.

Health care providers and public health professionals are overwhelmed in emergency departments, clinics, offices, and communities with the victims of mass shootings, homicides, suicides, accidental shootings, and firearm injuries. Medical professionals and our communities work to address the devastating and long-lasting physical and emotional effects of gun violence on victims, their families and their friends, but are hampered by the insufficient body of evidence-based research to use to point communities toward proven gun violence prevention programs and policies.

Former Representative Jay Dickey (R-AR), author of the current language that has effectively restricted gun violence research, recently noted that, "it is my position that somehow or someway we should slowly but methodically fund [gun] research until a solution is reached. Doing nothing is no longer an acceptable solution."

Here are some of the critical questions that enhanced research would help us answer:
1) **What is the best way to protect toddlers from accidentally firing a firearm?** Safe firearm storage works, but what kinds of campaigns best encourage safe storage? What safe storage methods are the most effective and most likely to be adopted? What should be the trigger pull on a firearm so a toddler can't use it?
2) **What are the most effective ways to prevent gun-related suicides?** Two-thirds of firearm related deaths are suicides. Are firearm suicides more spontaneous than non-firearm suicides? Do other risk factors vary by method? How do we prevent it in different populations—active military, veterans, those with mental illness, law enforcement or correctional officers, the elderly, or teenagers?
3) **What is the impact of the variety of state policies being enacted?** How are different policies around safe storage, mental health, public education, and background checks impacting firearm injuries and deaths?
The CDC's National Center for Injury Prevention and Control is an important part of answering these types of questions. Public health uniquely brings together a comprehensive approach connecting the complex factors that result in violence and injuries including clinical, social, criminal, mental health, and environmental factors. The impact of federal public health research in reducing deaths from car accidents, smoking and Sudden Infant Death Syndrome has been well proven. Decades ago, we did not know infant car seats should be rear-facing. Robust research on car accidents and subsequent legislation has helped save hundreds of thousands of lives without preventing people from being able to drive. It's time to apply the same approach to reducing gun violence in our communities.
As professionals dedicated to the health of the nation and to the application of sound science to improving the lives of our fellow Americans, we urge you to take action this year. Americans deserve to know that we are working with the best tools and information in the fight to reduce gun violence deaths and injuries.
As Congress works to craft the FY 2017 Labor-HHS-Education Appropriations bill, we urge you to provide the Centers for Disease Control and Prevention with funding for research into the causes and prevention of gun violence.
Thank you for your consideration. We look forward to working with you to improve health and protect the safety of all Americans.
Sincerely,
Academic Consortium for Integrative Medicine & Health Academic Pediatric Association Alameda Health System Department of Emergency Medicine American Academy of Family Physicians American Academy of Pediatrics American Association for the Advancement of Science American Association of Colleges of Pharmacy American Association of Nurse Practitioners American College of Emergency Physicians American College of Emergency Physicians, California Chapter American College of Occupational and Environmental Medicine American College of Physicians American Congress of Obstetricians and Gynecologists American Educational Research Association American Geriatrics Society American Medical Association American Medical Student Association American Medical Women's Association American Pediatric Society American Psychiatric Association American Psychological Association American Public Health Association American Society for Clinical Pathology American Society of Hematology American Thoracic Society American Trauma Society Arkansas Public Health Association Asociación de Salud Pública de Puerto Rico Association for Psychological Science Association of

American Universities Association of Medical School Pediatric Department Chairs Association of Population Centers Association of Public and Land-grant Universities Big Cities Health Coalition Boulder County Public Health Brigham Psychiatric Specialties California Center for Public Health Advocacy California Public Health Association-North Center for Science and Democracy at the Union of Concerned Scientists Central Oregon Medical Society Champaign-Urbana Public Health District Chicago Center for Psychoanalysis Chicago chapter Physicians for Social Responsibility Colorado Public Health Association Committee of Interns and Residents/SEIU Healthcare Congregation Gates of Heaven

Consortium of Social Science Associations Council of State and Territorial Epidemiologists Cure Violence Delaware Academy of Medicine / Delaware Public Health Association Doctors Council SEIU Doctors for America Eastern Association for the Surgery of Trauma Federation of Associations in Behavioral and Brain Sciences Florida Chapter of the American Academy of Pediatrics, Inc. Futures Without Violence Georgia Public Health Association Hawaii Public Health Association Health Officers Association of California Houston Health Department Illinois Public Health Association International Society for Developmental Psychobiology Iowa Chapter Physicians for Social Responsibility Iowa Public Health Association JPS Health Network Kansas Public Health Association Koop Institute KU Department of Preventive Medicine and Public Health Law and Society Association Lee County Health Department Local Public Health Association of Minnesota Louisiana Center for Health Equity Maine Public Health Association Maryland Academy of Family Physicians Minnesota Public Health Association Montana Public Health Association National AHEC Organization National Association of County and City Health Officials National Association of Medical Examiners National Association of Nurse Practitioners in Women's Health National Association of Social Workers National Association of State Emergency Medical Services Officials National Association of State Head Injury Administrators National Black Nurses Association National Hispanic Medical Association National Medical Association National Network of Public Health Institutes National Physicians Alliance National Violence Prevention Network Nevada Public Health Association

New Hampshire Public Health Association New Mexico Public Health Association North Carolina Public Health Association Ohio Public Health Association Ohio Public Health Association Oregon Academy of Family Physicians Oregon Physicians for Social Responsibility Oregon Public Health Association Pediatric Policy Council Physicians for Social Responsibility, Arizona Chapter Physicians for a National Health Program NY Metro Chapter Physicians for Reproductive Health Physicians for Social Responsibility / Northeast Ohio Physicians for Social Responsibility Wisconsin Physicians for Social Responsibility, Arizona Chapter Physicians for Social Responsibility/New York Physicians for the Prevention of Gun Violence Population Association of America Prevention Institute Psychonomic Society Public Health Association of Nebraska Public Health Association of New York City Public Health Institute Research!America RiverStone Health Safe States Alliance San Francisco Bay Area Chapter, Physicians for Social Responsibility Society for Adolescent Health and Medicine Society for Advancement of Violence and Injury Research Society for Mathematical Psychology Society for Pediatric Research Society for Psychophysiological Research Society for Public Health Education Society of Experimental Social Psychology Society of General Internal Medicine Southern California Public Health Association Southwest Ohio Society of Family Medicine Student National Medical Association Suicide Awareness Voices of Education Texas Doctors for Social Responsibility Texas Public Health Association Trauma Foundation Tri-County Health Department Trust for America's Health

United Physicians of Newtown Vermont Public Health Association Virginia Public Health Association Washington Chapter of the American Academy of Pediatrics Washington State Public Health Association Wellness Institute of Greater Buffalo Whiteside County Health Department

cc:

The Honorable Mitch McConnell
The Honorable Paul Ryan
The Honorable Harry Reid
The Honorable Nancy Pelosi Members of Congress

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: 30 Sep 2017 00:05:30 +0000
To: Mark Rosenberg
Subject: Re: Research on firearms injury

I'm glad it wasn't for sex because then I'd really be jealous!

From: Mark Rosenberg
Date: September 29, 2017 at 8:00:26 PM EDT
To: Mercy, James (CDC/ONDIEH/NCIPC)
Subject: Re: Research on firearms injury

Thanks, Jim. These are very good points. I haven't given up exercise for good. I just traded it, while on vacation, for eating.
On Fri, Sep 29, 2017 at 7:54 PM Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov> wrote:

> Hey Mark,
> That's great - I love the compassionate science, social justice point. That will resonate a with staff especially in DVP.
>
> Did you you know that NCIPC is responsible for the only major cause s of death in the US that are increasing - overdose and suicide. Hard to imagine because 20 years ago it motor vehicles and something else, oh yeah firearm deaths ! In any event our ability to persevere change in both the nature of injury morbidity and mortality and the political environment has always been important to our success. Change us a constant and to survive you need to make it your friend.
>
> Related to that you might consider saying something about the importance of partnership and collaboration for weathering change and having impact. You speak so well to that and it is one of those eternal truths that people should hear about .
>
> I am sure that anything you say will be great. Look forward to seeing you because you have apparently given up on exercise!
> Jim
>
> I think one thing that today reminds me of (given Price's resignation) is the constant changes in leadership

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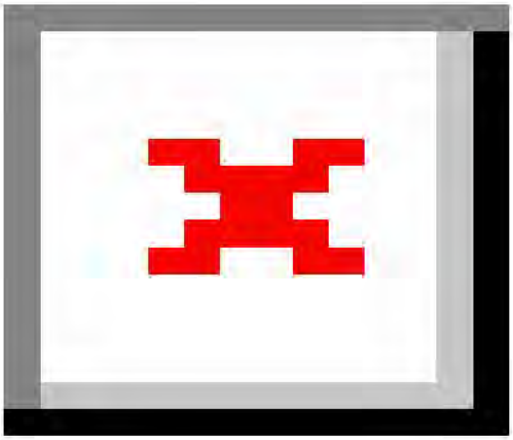
From: Mark Rosenberg <mrosenberg@taskforce.org>
Date: September 29, 2017 at 4:41:08 PM EDT

To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>
Subject: Re: Research on firearms injury

I think I am ready. I was going to say that our team's contribution was to push for the creation of a center. From VEB to having the first permanent director took 12 years. It wasn't easy but bringing about change is never easy, and injury control has always been an uphill battle. These are lives at risk that we are fighting for. People in Injury control who make a difference always bring together science and passion. I think it's compassion and social justice. The problems the center is working on today are still incredibly important and the center now makes me proud of everyone who has contributed and everyone still working there.

What should I point out and what should I add?
On Thu, Sep 28, 2017 at 10:22 AM Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov> wrote:

> Wow, so beautiful.
>
> Are you ready for the panel next week?
>
> **From:** Mark Rosenberg [mailto:mrosenberg@taskforce.org]
> **Sent:** Thursday, September 28, 2017 10:15 AM
>
> **To:** Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>
>
> **Subject:** Re: Research on firearms injury
>
> We are in Maine on rocks overlooking an incredible ocean.



On Thu, Sep 28, 2017 at 9:10 AM Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov> wrote:

> Hi Mark,
>
> I sent from my personal e-mail. Where have you been – we've missed you at the core training classes.
>
> Jim
>
> **From:** Mark Rosenberg [mailto:mrosenberg@taskforce.org]
> **Sent:** Wednesday, September 27, 2017 5:10 PM
> **To:** Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; James A. Mercy <jmercy7@gmail.com>
> **Subject:** Fwd: Research on firearms injury
>
> Jim,
>
> Please use this expanded email to respond.
>
> Can you fill this in with any details and let me know where I am off or wrong. I am trying to figure out

how the Dickey amendment and the clash with Congress set research back, specifically the research that was being done by this select group of researchers: Garen Wintemute, Phil Cook, Steve Teret, David Hemenway, Daniel Webster, and you. Here is an outline of what I remember:

Steve Teret--was one of the first in public health to start looking at guns from the perspective of injury control (as taught by Sue Baker); as a lawyer, brought in the legal community to look at the public health perspective. The public health perspective of modifying the "agent" of injury led him to look at smart guns. He mentored and taught a group of key researchers including Garen Wintemute, Daniel Webster, Jens Ludwig. He also spoke up about CDC's timidity or outright ban on letting researchers use CDC funds to attend meetings where other people were talking about what could have been construed as "gun Control." Steve gradually moved away from gun research to running the HOpkins Injury Control research center, then to becoming a vice-dean and an administrator.

David Hemenway--

I don't think David had done much in the area of gun violence research per se before the congressional attack, but

he actually got a big boost from getting the money that we asked George Soros to give us at CDC for gun research, when CDC told us it was too hot to handle.

We originally worked with the Robert Wood Johnson Foundation who wanted to restore the research money that Congress had taken away from gun violence prevention research. But they had a board member who was an NRA advocate and he vetoed the proposal by the president and staff of RWJF. Hemenway d

eveloped a very strong focus on the public health approach, and gun suicide. Focused on demographic and epi analysis.

Phil Cook--started looking at suicide, and economics of gun trafficking,

emphasizing

the grey market impacts of restricting access to legal sales.

Phil was an economist with a strong interest in public policy and the impact of policies when implemented.

Garen Wintemute--he had been looking at how criminals acquire guns, especially saturday night specials, cheap handguns, and had done some work on mapping the handgun industry. He published this in a report that I think was called Ring of Fire. He did not let the drying up of CDC funding stop his research. It is not clear that it even slowed him down. If anything, it probably re-energized him and led to his re-

doubling his efforts. He starting looking at large data sets in California that would let him look at how different laws that were passed in California were impacting gun deaths and injuries and how restricting access to firearms by persons who violated extant laws would reduce or affect firearm injuries.

Daniel Webster--I don't think he was actually doing gun violence research in 1996 but he certainly started doing research in subsequent years. His main focus has been on evaluating the impact of different policies, like shall-issue laws that made access to firearms by high-risk persons easier. He has worked to show flaws in papers published by pro-gun "researchers." He is focusing on the impact of laws designed to keep firearms out of the hands of people who break the law.

Mark

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: 28 Sep 2017 14:22:35 +0000
To: Mark Rosenberg
Subject: RE: Research on firearms injury

Wow, so beautiful.
Are you ready for the panel next week?
From: Mark Rosenberg [mailto:mrosenberg@taskforce.org]
Sent: Thursday, September 28, 2017 10:15 AM
To: Mercy, James (CDC/ONDIEH/NCIPC)
Subject: Re: Research on firearms injury
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On Thu, Sep 28, 2017 at 9:10 AM Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov> wrote:

> Hi Mark,
> I sent from my personal e-mail. Where have you been – we've missed you at the core training classes.
> Jim
> **From:** Mark Rosenberg [mailto:mrosenberg@taskforce.org]
> **Sent:** Wednesday, September 27, 2017 5:10 PM

To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; James A. Mercy <jmercy7@gmail.com>
Subject: Fwd: Research on firearms injury

Jim,

Please use this expanded email to respond.

Can you fill this in with any details and let me know where I am off or wrong. I am trying to figure out how the Dickey amendment and the clash with Congress set research back, specifically the research that was being done by this select group of researchers: Garen Wintemute, Phil Cook, Steve Teret, David Hemenway, Daniel Webster, and you. Here is an outline of what I remember:

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"researchers." He is focusing on the impact of laws designed to keep firearms out of the hands of people who break the law. Mark

From: Foti, Kathryn (CDC/OD/OCS)
Sent: 15 Jun 2016 20:49:54 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Morris, Dena (CDC/OD/CDCWO)
Subject: Re: Schatz key take aways if helpful for tomorrow for Dr Frieden

Thanks!

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 15, 2016 08:46 PM Eastern Standard Time
To: Foti, Kathryn (CDC/OD/OCS); Morris, Dena (CDC/OD/CDCWO)
Subject: Schatz key take aways if helpful for tomorrow for Dr Frieden

Met with Aimee his health LA- she's a pediatrician so gets public health/ injury prevention
Falls- big interest of the Senator- they had been briefed by American College of Prev Med re the CPT code we have been working with them on- this CPT code was recently rejected by AMA- we will be resubmitting this month. They may be interested in sending letter of support to AMA re this (of note, HI has one of the lowest rates of falls in US- has good community based Tai Chi program)
Suicide- advocates recently met with them- I mentioned the FY17 request and what our vision for work in suicide would be (community level interventions in states and tribal communities; implementing evidence based approaches; expanding NVDRS nationally)- she said they are extremely interested in suicide and would like to support our efforts
FV- she brought this up esp with AMA resolution this week re lifting Dickey amendment. I talked about the work we were doing (child injury papers, optional BRFSS module, ICRC projects) but talked about the importance of report language and/ or appropriation. She wants to have a follow up discussion on this to see how they can help move this forward

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: 19 Apr 2016 12:38:52 +0000
To: Mercy, James (CDC/ONDIEH/NCIPC)
Subject: RE: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

Got it- let me check in with opp and see if it's been submitted yet or not

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Tuesday, April 19, 2016 8:03 AM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Subject: FW: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

Deb,
I'm a little concerned about how the answer to #9 has evolved. As it is now it's not really accurate.
Jim

From: Reimels, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, April 18, 2016 9:48 AM
To: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Cc: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>; Patterson, Sara S. (CDC/ONDIEH/NCIPC) <afo0@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Subject: FW: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

Hello! This is looking really good, but we have some concerns about some of the edits that were made. The response to number 9, for example, jumps out at us as being incorrect and misleading now. In response to Linda's comment on the response to question 3, it would be good to add an introductory sentence to the NVDRS that distinguishes NVDRS as a surveillance system that is called out in Now is the Time, but is not part of the $10M request. Can we still provide feedback on this version? Thanks!

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, April 18, 2016 9:02 AM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Reimels, Elizabeth (CDC/ONDIEH/NCIPC) <ixn2@cdc.gov>
Subject: FW: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690
From: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, April 18, 2016 8:15 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; DVP Policy Requests (CDC) <dvppolicyrequests@cdc.gov>
Cc: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) <vsx6@cdc.gov>; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) <xgf0@cdc.gov>; Patterson, Sara S. (CDC/ONDIEH/NCIPC) <afo0@cdc.gov>; Asekun, Adeyelu (CDC/ONDIEH/NCIPC) <fpg8@cdc.gov>
Subject: FYI: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

FYI...this is the latest, final or very near final.

From: Hoffmann, Lauren (CDC/OD/OCS)
Sent: Monday, April 18, 2016 8:04 AM
To: Lubar, Debra (CDC/OCOO/OFR/OA) <dpl9@cdc.gov>; Patterson, Sara S. (CDC/ONDIEH/NCIPC) <afo0@cdc.gov>
Cc: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Subject: FW: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper -

Folder 2353690
Importance: High
Deb —I think Dr. Frieden is waiting for you to say that you are OK with the response for #6 and then he will clear. It was the only concern/question that he raised.
Sara—Attached is what we expect to be the final.
Lauren
Lauren Hoffmann, MA, BS I Lead, High Profile Action Team, Division of Issues Management, Analysis and Coordination (IMAC) I Office of Chief of Staff I Office of the Director I Centers for Disease Control and Prevention
1600 Clifton Road, NE, Atlanta, GA 30333 I Office: 404-639-7126 I Mobile: 404-547-3997 I E-mail: cpf5@cdc.gov
Forecast. Coordinate. Communicate.

From: Frieden, Thomas (Tom) (CDC/OD)
Sent: Friday, April 15, 2016 6:13 PM
To: Payne, Rebecca L. (CDC/OD/OCS) <rco0@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>; Lubar, Debra (CDC/OCOO/OFR/OA) <dpl9@cdc.gov>
Subject: RE: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690
I'm ok w it if Deb is

From: Payne, Rebecca L. (CDC/OD/OCS)
Sent: Friday, April 15, 2016 5:03 PM
To: Frieden, Thomas (Tom) (CDC/OD) <txf2@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>; Lubar, Debra (CDC/OCOO/OFR/OA) <dpl9@cdc.gov>
Subject: RE: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690
Re funding – we are being consistent with past statements and responses. The language you are asking about is consistent with responses we've sent to Congress via other inquiries. Our funded research in various violence related topic areas may touch on firearms even if it's not the full scope of the research. For example, the evaluation of Safe Streets, a violence interrupter program in Baltimore, would touch on firearm access and use even though the program isn't directly addressing firearms.
+Deb in case this raises additional questions

From: Payne, Rebecca L. (CDC/OD/OCS)
Sent: Friday, April 15, 2016 4:47 PM
To: Frieden, Thomas (Tom) (CDC/OD) <txf2@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>
Subject: RE: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690
The appendices are in the end of the word doc but pasted the full doc below as well – we are checking on the funding q

The Honorable Thomas R. Carper
Ranking Member, Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510
Dear Senator Carper:

Thank you for your letter regarding the status of the Centers for Disease Control and Prevention's (CDC) research into the causes and prevention of gun violence. CDC appreciates your concerns and those of the Committee on Homeland Security and Governmental Affairs, and is committed to protecting the health, safety, and security of the American people.

Enclosed, please find detailed responses to the specific questions outlined in your letter. We appreciate the Committee's interest in this important public health issue.

If you have additional questions or concerns, please contact Cristi Schwarcz in the CDC Washington Office at Cschwarcz@cdc.gov or (202) 245-0600.

Sincerely,

Thomas R. Frieden, MD, MPH
Director, CDC
Enclosure

Centers for Disease Control and Prevention (CDC) Response to the Senate Committee on Homeland Security and Governmental Affairs regarding Gun Violence Research

1. **Please describe the CDC's policy toward scientific research into the causes and prevention of gun violence.**

   Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. While CDC's National Center for Injury Prevention and Control (NCIPC) has no specific program dedicated to firearm violence research and prevention, firearms are a mechanism (cause) of injury. Therefore, CDC addresses firearm-related violence prevention in the context of addressing related areas, including youth violence, child maltreatment, domestic violence, and sexual violence. These areas coincide with topical line items that are supported through CDC's annual appropriation for research and non-research activities. The Fiscal Year (FY) 2017 President's Budget includes $10 million to dedicate to gun violence prevention research.

2. **Has the CDC or the Department of Health and Human Services' (HHS) Office of the General Counsel conducted any analysis of the Dickey Amendment, including the types of gun violence research that are still permissible? If so, please provide this analysis.**

   In 1997, after the Dickey Amendment was passed, CDC interpreted the amendment as prohibiting impermissible lobbying related to advocating or promoting gun control. CDC also interpreted the amendment to mean that activities that supported the collection of firearm injury-related data and engagement in scientific, public health research directed to preventing injuries from violence and firearms were still permissible.

   More recently, in January 2013, the President issued a Presidential Memorandum, "Engaging in Public Health Research on the Causes and Prevention of Gun Violence" (Presidential Memorandum). This Presidential directive outlines the types of gun violence research that are permissible, including conducting or sponsoring research into the causes of gun violence and ways to prevent it, identifying the most pressing research questions with the greatest potential public health impact, and assessing existing public health interventions to prevent gun violence.

   The President's plan to reduce gun violence, "Now is the Time," also states that the language in the Dickey Amendment, limiting the use of appropriated funds to "advocate or promote gun control," does not bar CDC from conducting research on the causes of gun violence, noting specifically that "research on gun violence is not advocacy."

3. **In the aftermath of the shooting at Sandy Hook Elementary School in December 2012, President Obama issued a memorandum directing the Secretary of Health and Human Services (HHS), through the Director of the CDC and other agencies within HHS, to conduct or sponsor research into the causes of gun violence and the ways to prevent it. Please describe the efforts CDC has taken in response to this memorandum.**

   In January 2013, in response to the President's memorandum, CDC asked the Institute of Medicine (IOM), in collaboration with the National Research Council (NRC), to convene

a committee to engage diverse stakeholders and identify the most pressing research questions on

gun violence, including those with the greatest potential public health impact. The IOM/NRC released their report, which is available at www.nationalacademies.org/hmd/Reports/2013/Priorities-for-Research-to-Reduce-the-Threat-of-Firearm-Related-Violence.aspx, on June 5, 2013. In addition, the CDC Foundation, in collaboration with CDC, commissioned the IOM/NRC to develop and disseminate three supplemental discussion papers focusing on youth possession and acquisition of firearms, the relationship between alcohol and firearm violence, and firearm access by persons at risk of harming themselves or others. These papers, available at www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Youth-Acquisition-Carrying-Firearms-US.pdf, www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Alcohol-Firearms.pdf, and www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Firearms-Suicide-Homicide.pdf, were released in late 2014.

In February 2014, CDC met with a number of Executive Branch agencies, including representatives from HHS and the Department of Justice, to discuss approaches for strengthening data to understand patterns and characteristics of firearm violence, address research questions identified in the IOM/NRC report, ensure that research carried out by the different agencies is complementary and builds upon individual and collective strengths, and determine opportunities to collaborate on current or future efforts. For examples of CDC investigations, analyses of surveillance, and other data to document the public health burden of firearm injuries, see **Appendix A**.

In FY 2015, with increased appropriations, CDC expanded the National Violent Death Reporting System (NVDRS) from 18 to 32 participating states. In FY16, utilizing increased appropriation ($4.7 million), CDC plans to expand the NVDRS to an additional four to seven states. NVDRS is a state-based surveillance system that pools information about the "who, when, where, and how" from data on violent deaths to provide insights on "why" they occur. It gives states and communities a clearer understanding of violent deaths to guide local decisions about efforts to prevent violence and track progress over time. Findings from NVDRS have resulted in tailored interventions, including increased veterans services to prevent suicide, ensuring child witnesses of domestic violence homicides are linked to social services, and screening older adults for depression.

4. **In April 2013, the National Center for Injury Prevention and Control asked the Institute of Medicine to recommend a research agenda on the public health aspects of firearm-related violence. Please describe the actions the CDC plans to take in response to the findings of the Institute of Medicine report issued in June 2013.**

   The President's FY 2017 Budget request includes $10 million in funding for gun violence prevention research. These funds would enable CDC to pursue research priorities identified in the IOM/NRC report.

Should funding become available, CDC will pursue research activities that align with the priorities identified in the IOM/NRC report, *Priorities for Research to Reduce the Threat of Firearm-Related Violence* (available at www.nap.edu/read/18319/chapter/1). This includes understanding the characteristics of firearm violence (e.g., patterns of access and use among children and youth, and among high-risk racial/ethnic minority populations; rural/urban differences in firearm-related violence); the risk and protective factors for homicide and suicide firearm violence (e.g., alcohol, other situational or environmental factors; the factors influencing non-fatal firearm violence); and the effectiveness of interventions to prevent firearm violence (e.g., safe storage practices; whether existing evidence-based approaches and policies for preventing interpersonal violence are effective in reducing firearm-related deaths and injuries).

5. **From 1996 to the present, please describe notable examples of research conducted or funded by the CDC, including research by or through the National Center for Injury Prevention and Control, related to understanding gun violence.**

   For a list of projects funded through the research grant programs, the Injury Control Research Centers (ICRC), and the first cycle of the Academic Centers of Excellence for Youth Violence Prevention (ACE), please see **Appendix B**.

   5a. Please also provide all instances when the CDC included requests for gun violence research in its research proposal solicitation materials.

   Firearm-related research priorities were included in funding solicitations from 1996-2001 within the context of addressing assaultive behavior among youth, suicidal behavior, intimate partner violence and sexual violence. The funding solicitations for the ICRCs and ACEs were broad and did not include specific priorities for firearm-related research. For a list of these funding announcements, please see **Appendix C**.

6. **For each year from FY1996 to FY2015, what portion of the CDC's budget, including the budget of the National Center for Injury Prevention and Control, has been devoted to gun violence research?**

   In FY 1997, Congress redirected $2.6 million from gun violence prevention activities to traumatic brain injury. CDC addresses firearm-related violence prevention in the context of other violence-related areas, including youth violence, child maltreatment, domestic violence, and sexual violence. These areas coincide with topical line items that are supported through CDC's annual appropriation for research and non-research activities. As previously noted, CDC has requested $10 million to dedicate to gun violence prevention research in the FY 2017 President's Budget.

   Because firearms are a cause of injuries in these related areas, CDC has awarded research grants that address firearms as part of their scope, based on a competitive process. Proposals are evaluated for scientific and technical merit by an external peer review group, in accordance with CDC peer review policy and procedures, using stated review criteria. Since awards are competitive, the funding levels for firearm-related activities from 1997 through 2015 have ranged from about $100,000 to just over $1 million. Comparisons to the total NCIPC budget or total CDC budget are not informative because the agency's budget structure and scope have changed dramatically in the past 20 years.

7. **Each year, CDC's Division of Violence Prevention solicits investigator-initiated research via an "RO1" Grant Program Announcement. The language in these announcements signals to grant-seeking public health researchers the research priorities of the CDC and its Division of Violence Prevention. Please describe any Division of Violence Prevention's RO1 Grant Program Announcements related to gun violence research put forward from 1996 to the present**.

   Firearm-related research priorities were included in funding solicitations from 1996-2001 within the context of addressing assaultive behavior among youth, suicidal behavior, intimate partner violence, and sexual violence. All R01applications were evaluated for scientific and technical merit by an external peer review group, in accordance with CDC peer review policy and procedures, using stated review criteria. Following initial peer review, recommended applications received a second level of review. A variety of factors were considered in making funding decisions, such as scientific and technical merit of the proposed project as determined by scientific peer review, availability of funds, and relevance of the proposed projects to program priorities.

   The research solicitations during these years focused on enhancing the understanding of social, economic, and environmental factors that may impact the frequency and severity of these forms of violence. The research solicitations also focused on enhancing evaluations of policies, programs, or other interventions that may reduce morbidity, mortality, and disabilities associated with suicidal behavior, assaultive violence, firearm-related injuries, intimate partner violence, and sexual violence. Researchers proposed firearm-related research projects in the Injury Control Research Center (ICRC) grants and in the first cycle of funding for the Academic Centers of Excellence for Youth Violence Prevention (ACEs) during this period. The funding solicitations for the ICRCs and ACEs were broad and did not include specific priorities for firearm-related research. **See Appendix C**.

   The funding priorities for the R01 investigator-initiated research grants from 2002-2012 emphasized dissemination research and effectiveness research, particularly the effectiveness of primary prevention strategies to prevent child maltreatment, intimate partner violence, sexual violence, youth violence, and suicidal behavior. The research objectives outlined in Funding Opportunity Announcements are based on priorities in the NCIPC Research Agenda.

8. **The National Violent Death Reporting System collects and combines data from multiple sources to provide states and communities with a more complete record of the circumstances surrounding violent deaths. Participation from all 50 states would significantly increase the amount of data available to the National Violent Death Reporting System and, thereby, improve its effectiveness. In how many states has the National Violent Death Reporting System been implemented?**

   NVDRS has been implemented in 32 states, and with the FY2016 appropriations increase, the system will expand to include an additional four to seven states. The funding

announcement was recently released, and states' applications are due to CDC on May 27. Final funding decisions will be made by September. CDC has requested an increase of $7.6 million in FY 2017 in order to support NVDRS nationwide.

8a. How many states have applied to be included in this system?

Over the years, 41 states have applied to the NVDRS funding opportunity announcements. This year, 18 states and Washington, DC, are eligible to apply. The remaining 32 states are funded for multiple years. Therefore, they are not eligible to apply this year.

8b. What circumstances have prevented all state applicants from being added to the National Violent Death Reporting System?

Currently, NVDRS does not include all state applicants because levels of funding are not sufficient to support every state. Therefore, all prior funding opportunity announcements for NVDRS have been competitive. Based on objective reviews, criteria for not funding prior applicants include lack of an injury prevention (or other suitable public health) infrastructure to provide adequate staffing and resources, inability to develop or demonstrate partnerships with data providers (vital registrars, coroners/medical examiners, or law enforcement) required for NVDRS, problems with grant/application writing, and/or state legislation that restricts sharing of data required for NVDRS.

The FY 2017 President's Budget includes $23.5 million in funding for the National Violent Death Reporting System. With the total request of $23.5 million, CDC will be able to complete the expansion of NVDRS to all 50 states and Washington, DC.

CDC expects that all states will apply for NVDRS funding should full funding be provided to support a national system. In FY 2016 and FY 2017, to prepare for additional expansion, CDC and our partners will continue to work with unfunded states to determine barriers related to collecting violent death data and develop strategies to address identified barriers. CDC has and will continue to collaborate with partners to provide training to previously unfunded states to offer guidance for implementing the system and for facilitating collaboration between previously unfunded states and experienced states.

9. **Has the CDC previously entered into any agreements with the National Rifle Association offering to provide advanced notice of any publication on the subject of gun violence? If so, please provide a description of any such agreements as well as communications and documents memorializing the agreements.**

   CDC routinely informs stakeholder organizations, including the National Rifle Association, when articles of interest, such as articles on firearm-related violence, are released.

10. **From 1996 to the present, has the CDC instructed any employee or researcher to not conduct scientific research on gun violence? Has the CDC instructed any employees or researchers to re-write reports submitted for publication to avoid using any variation of the word "gun"?**

    CDC has not instructed employees or researchers to refrain from scientific research on gun violence. To ensure scientific integrity, technical accuracy, consistency with appropriations language, and usefulness to the intended audience, CDC has a standard

agency review process for any manuscript or report produced by CDC scientists. Agency review is not specific to any topic area.

In the course of reviewing manuscripts or reports on firearm violence, CDC has asked employees to use correct terminology—for example, to say "died as a result of a firearm-related injury" vs. "died from a firearm" in the same way as one would write "died as a result of a motor-vehicle crash" vs. "died from a car."

11. **What remedies are available to CDC researchers who believe their scientific research has been inappropriately suppressed or discouraged? Please describe any review or appeals processes and include a list of the offices or review boards who would address any such concerns.**

CDC is committed to a transparent research process and works to conduct scientific research in a manner that increases our knowledge of public health and ensures scientific quality and integrity. As diligent stewards of the public funds entrusted to us, CDC programs work to ensure that our scientific efforts meet established public health goals. Working with their leadership, scientists and subject matter experts ensure accuracy, validity, and appropriateness of results and findings and follow best practices to assure scientific quality and integrity. CDC scientists are required to complete scientific integrity and quality training.

CDC has established an organizational framework that supports its scientists through the Associate Director for Science (ADS) structure. Through the ADS structure, CDC scientists can consult with their manager, leader, or ADS in their immediate program if they have concerns about research decisions. The ADS in the immediate program may escalate the matter to ADSs serving at higher organizational levels within the agency, as needed. Scientists may also escalate the matter to an ADS serving at higher organizational levels if they are in disagreement with the ADS in their immediate program or believe their research has been inappropriately discouraged.

To enhance the agency's strategic approach to scientific research, CDC also has established the Excellence in Science Committee (EISC). The EISC provides a forum for information exchange among CDC's ADSs. As an advocate for scientific quality and integrity, the EISC serves as a consulting body for science-related issues and makes recommendations when appropriate.

Appendix A – Examples of CDC firearm-related surveillance activities and analyses

Fowler KA, Dahlberg LL, Haileyesus T, Annest JL. Firearm injuries in the United States. Preventive Medicine 2015; 79:5-14.

Sullivan EM, Annest JL, Simon TR, Luo F, Dahlberg L. Suicide trends among persons aged 10–24 years — United States, 1994–2012. Morbidity and Mortality Weekly Report 2015; 64(08):201-205.

Kegler SR, Mercy JA. Firearm homicides and suicides in major metropolitan areas-United States, 2006-2007 and 2009-2010. Morbidity and Mortality Weekly Report 2013; 62(30):597-602.

Sullivan, E., Annest, J. L., Luo, F., Simon, T. R., & Dahlberg, L. L. Suicide among adults aged 35–64 years—United States, 1999–2010. Morbidity and Mortality Weekly Report, 2013; 62(17):321-325.

Ferdon CD, Dahlberg LL, Kegler S. Homicide rates among persons aged 10-24 years – United States, 1981-2010. Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, 2013; 62(27):545-548.

Egley A, Logan J, McDaniel D. Gang Homicides — Five U.S. Cities, 2003–2008. Morbidity and Mortality Weekly Report, 2012; 61(03):46-51.

Appendix B – CDC firearm-related research projects

Projects listed below were funded through the research grant programs, the Injury Control Research Centers (ICRC) and the first cycle of the Academic Centers of Excellence for Youth Violence Prevention (ACE).

Jeffrey Fagan
Situational Contexts of Gun and Non-Gun Injuries
R49/R01 1995-1997

Jeffrey Fagan
Lethal & Non-Lethal Adolescent Violence: Social, Economic, & Neighborhood
R49/R01 1996-1998

David McDowall
Injury Prevention Effects of Violence Interventions
R49/R01 1996-1998

David Grossman
Firearm Storage Device Evaluation
R49/R01 1998-2000

David Hemenway
Adult Firearms Survey
ICRC 1998-2001 (Harvard)

Daniel Webster
Understanding risks for retaliatory shootings and opportunities for prevention
ICRC 1999-2000 (Hopkins)

Daniel Webster
Estimating the effects of laws setting minimum legal age for handgun purchase and possession on youth suicide and homicide
ACE 2000-2005

David Hemenway
Evaluation of State-Level Firearms Policies
ICRC 2001-2006 (Harvard)

Appendix C – Research solicitations

A synopsis of firearm-related funding announcements, from 1996-2001, within the context of addressing assaultive behavior among youth, suicidal behavior, intimate partner violence and sexual violence, is provided below.

1996

FOA# CE96-011 Grants for Violence-Related Injury Prevention Research

Grant applicants should concentrate on the need to reduce morbidity, mortality, and disabilities caused by suicidal behavior, assaultive behavior among youth, and family and intimate partner violence.

1. Injury from Suicidal and Assaultive Behavior

Enhancing our understanding of social, economic, and environmental factors that may affect suicidal behavior:

- Study how choice of method (firearm, overdosing, etc.) in planning or attempting suicidal behavior is influenced by cultural, social, or environmental factors.
- Conduct research to determine the nature of suicide risk among gay and lesbian persons in comparison to the general population.
- Evaluate policies, programs, or interventions that may reduce suicidal behavior via the modification of social, economic, or environmental circumstances.
- Assess the effectiveness of interventions that attempt to remove access to lethal means in reducing injury and severity of injury from suicidal behavior.

Enhancing our understanding of the importance of social and economic factors that influence assaultive behavior among youth:

- Study why many socioeconomically disadvantaged youth do not engage in assaultive behavior despite their socioeconomic status.
- Undertake research to increase our understanding of relationships between poverty and assaultive behavior among youth.
- Study how unequal access to criminal justice, health care, and educational systems is related to assaultive behavior.
- Evaluate policies, programs, or interventions that may reduce assaultive behavior among youth via the modification of social or economic circumstances.

2. Family and Intimate Violence Prevention

Address and define the needs of mothers and children in families where intimate violence occurs.

- Undertake research to determine effective interventions for mothers and children in families with ongoing violence
- Conduct studies to determine which mothers and children are most likely to be helped by interventions designed for families with ongoing violence
- Examine variables related to mothers, children, and families that may predict intervention effectiveness
- Conduct studies related to the impact of children witnessing violence in their families.

Define the incidence or prevalence of functional limitations and disabilities among women as a result of intimate partner violence.

- Quantify injuries sustained (nature and severity) and subsequent short and long-term (1-year) functional limitations and disability
- Quantify the use of acute care, mental health, rehabilitation, and social services

- Identify risk factors for adverse outcomes

1998

FOA# CE98-029 Grants for Violence-Related Injury Prevention Research

Grant applicants should concentrate on the need to reduce morbidity, mortality, and disabilities caused by suicidal behavior, firearm-related injury, sexual violence, or intimate partner violence.

1. *Injury prevention research addressing emerging issues in suicidal behavior*
   - Conduct research to develop and improve measurement instruments for the identification and study of suicides and suicide attempts in surveys, research studies, and surveillance systems.
   - Conduct research designed to improve understanding of the nature of suicide risk among emerging high-risk populations such as young African American males.
   - Conduct research that further illuminates understanding of the contribution of potential risk factors for suicide such as impulsivity, sexual orientation, and hopelessness.
2. *Injury prevention research addressing firearm-related injuries among children and adolescents*
   - Conduct research to improve understanding of the motivations and deterrents for weapon carrying behavior among adolescents at high risk for firearm-related injuries.
   - Conduct research that estimates injury risk associated with firearm storage or carriage practices.
   - Conduct research that addresses the effects of firearm safety training and education programs on firearm storage and carriage practices.
3. *Injury prevention research addressing sexual violence or intimate partner violence*
   - Conduct research to address the impact of welfare and welfare-to-work programs on women (and their children) who experience intimate partner violence.
   - Conduct research to determine the effectiveness of prevention programs for adolescent males at risk for perpetration of sexual violence or intimate partner violence or intervention programs for perpetrators of sexual violence or intimate partner violence.
   - Conduct research on risk factors for perpetration of sexual violence.

1999

FOA# CE99-055 Extramural Grants for Violence-Related Injury Evaluation Research

The purposes of this program are to: evaluate the effectiveness and/or cost effectiveness of interventions and policies designed to reduce morbidity, mortality, and disabilities caused by suicidal behavior, firearm-related injury, sexual violence, or intimate partner violence.

1. In the area of suicide, there is particular interest in projects to evaluate suicide prevention interventions for general or high risk populations and projects to evaluate services provided in various settings such as a managed care setting.
2. In the area of firearm injuries, there is particular interest in projects evaluating prevention programs and policies that offer promise in preventing firearm injuries among children and adolescents (e.g., safe storage of firearms in homes, safe gun technology, curricula to promote gun safety for children and adolescents).

3. In the areas of sexual violence and intimate partner violence, there is particular interest in evaluation research to determine the effectiveness of:
    - Prevention programs for adolescent males at risk for perpetration of sexual violence or intimate partner violence; or
    - Intervention programs for perpetrators of sexual violence or intimate partner violence.

2001

FOA# CE01-016 Grants for Violence-Related Injury Prevention Research

Research is sought to better understand the etiology of violence and its consequences, to determine how best to prevent violence-related injury among different segments of the population and in different settings, and how best to reduce the severity of the emotional and physical consequences of violence.

1. *Improve understanding of the etiology of violence (i.e., interpersonal youth violence, child abuse, intimate partner violence, suicide, and sexual assault) and its consequences through research that addresses:*
    - The independent, additive, interactive, and sequential effects of psychological, socioeconomic, and environmental risk and protective factors.
    - Factors that have differential effects on the onset, persistence, escalation, de-escalation, or desistance of violent offending at different ages.
    - Factors that increase the severity of the emotional and physical consequences of violence and suicidal behavior.
    - The effect of social and economic risk and protective factors such as poverty, social contagion, social norms, and social capital on interpersonal violence.
    - The effect of psychological, social, and environmental factors not directly related to mental health on suicide.
    - The risks and benefits of firearm access or carrying.
2. *Improve understanding of the relationships between different types of violence. of particular concern are:*
    - The relationship between intimate partner violence victimization and perpetration to child abuse.
    - The effects of exposure to child abuse and intimate partner violence on suicidal behavior.
    - The effects of witnessing violence as a child in the home and community on violent behavior during adolescence and adulthood.
3. *Design and test preventive interventions for intimate partner violence, sexual violence, suicidal behavior, and child abuse.*
4. *Evaluate the feasibility and impact of screening and intervention methods in the acute medical care setting for youth interpersonal violence, child abuse, suicidal ideation, and intimate partner violence.*
5. *Advance our understanding of the effectiveness of interventions to prevent youth violence by evaluating:*
    - The long-term impact of promising interventions.
    - Multifaceted interventions to prevent youth violence.
    - The effect youth-violence-prevention strategies in diverse cultural and social settings.

- The cost effectiveness of promising interventions

_____
2015

FOA# CE15-001 Research Grants for Preventing Violence and Violence-Related Injury

NCIPC is soliciting investigator-initiated research that will help expand and advance knowledge in three areas: (1) how best to disseminate, implement, and translate evidence-based primary prevention strategies, programs and policies designed to reduce youth violence; (2) what works to prevent violence by rigorously evaluating primary prevention strategies, programs, and policies; and (3) research to determine ways to effectively prevent serious and lethal interpersonal and self-directed violence. The following research objectives are the focus of this announcement:

1. *Research to prevent youth violence:*
   - Dissemination/implementation/translation research to accelerate the adoption of evidence-based strategies, programs, and policies to prevent youth violence. There is particular interest in research that examines how models that have shown preventive effects on violence outcomes at the community level (e.g., Communities That Care, Cardiff Violence Prevention Program) can be adopted for use in high risk communities. Prevention models that bring together different sectors within communities to make data driven decisions about the set of evidence-based prevention activities that are most appropriate for the local community and then ensure implementation of those strategies have the potential to reduce risk for violence at the community level. Additional research is needed to help communities understand the capacity needed to implement these models, how the models can be appropriately adopted, and the effects of modifications on violence outcomes.
   - Effectiveness research to determine which community-level and societal-level strategies, programs, and policies effectively prevent youth violence. This includes studies to assess the effectiveness of economic development schemes (e.g., business improvement districts) and other efforts to improve the physical, social, and economic characteristics of neighborhoods; and the effectiveness of strategies aimed at reducing the level and concentration of community risk factors. There is also interest in the area of youth violence to assess the economic efficiency of strategies, programs and policies designed to prevent youth violence.
   - Effectiveness research to prevent serious and lethal violence among youth. Although there is a strong and growing evidence-base to prevent youth violence (e.g., universal school-based programs, parent/family focused interventions), there is less evidence addressing the more serious forms of violence among youth. Research is needed to determine ways to effectively prevent serious and lethal violence involving youth, particularly identifying and evaluating strategies addressing the leading mechanisms of youth homicide and assault-related injuries.
2. *Research to prevent teen dating violence, intimate partner violence, and sexual violence:*
   - Within the context of teen dating violence, intimate partner and sexual violence, there is interest in assessing the efficacy/effectiveness of primary prevention strategies aimed at preventing the initial perpetration of violence and promoting respectful, nonviolent relationships.6 Intervening in ways that prevent the initial perpetration of violence, that alter developmental trajectories leading to initial perpetration of violence, and that

promote an environment of nonviolence and respect is key to eliminating sexual and intimate partner violence.

- Effectiveness research to determine which community-level and societal-level strategies, programs, and policies effectively prevent teen dating violence, intimate partner and sexual
  violence. This includes studies to assess the effectiveness of economic schemes (e.g., microfinance, business improvement districts) and other efforts to improve the physical, social,
  and economic characteristics of neighborhoods and other settings; studies to assess the effectiveness of social and cultural norm change strategies at the community and societal level aimed at changing social contexts that condone or tolerate aggression and perpetration; and the effectiveness of strategies aimed at reducing the level and concentration of community risk factors.
- There is also interest in studies to assess the effectiveness of programs, policies, or strategies to prevent injuries and deaths in the context of teen dating violence and intimate partner violence. Women are much more likely than men to be injured or killed in incidents of violence between intimate partners. Research is needed to determine ways to effectively prevent serious and lethal violence against intimate partners, particularly identifying and evaluating strategies addressing the leading mechanisms of intimate partner homicide.

3. *Research to prevent suicidal behavior:*

- In the area of suicidal behavior, there is interest in efficacy/effectiveness studies of social, economic, and environmental primary prevention strategies to prevent suicidal behavior, including strategies aimed at enhancing connectedness for groups at high-risk for suicidal behavior and community-level efforts to reduce social isolation and stigma associated with seeking help for personal crises. There is also interest in studies to determine whether evidence-based programs for other forms of violence can also prevent suicidal behavior. Suicidal behavior and interpersonal violence share a number of risk and protective factors. However, only a limited number of evaluations of strategies that have demonstrated reductions in interpersonal violence have examined the impact of these strategies on suicidal behavior.
- There is also interest in studies assessing the effectiveness of programs, policies, and other intervention strategies to reduce access to lethal means. Research indicates that the means used in suicidal behavior (e.g., jumping from a bridge, hanging or suffocation versus taking pills) has a substantial impact on whether the act results in significant injury or death. Strategies related to means restriction, however, have rarely been rigorously evaluated particularly for their impact and feasibility for broader implementation. Knowledge is also limited regarding the effects of means restriction on different age groups, and how means substitution (i.e., switching from one suicide method to another) will limit the effectiveness of means-restriction strategies.

Grants for Injury Control Research Centers (ICRCs)

The purposes of this program are: 1) To support injury prevention and control research on priority issues as delineated in: Healthy People 2000; Injury Control in the 1990's: A National Plan for Action; Injury in America; Injury Prevention: Meeting the Challenge; and Cost of

Injury: A Report to the Congress; 2) To support ICRCs which represent CDC's largest national extramural investment in injury control research and training, intervention development, and evaluation; 3) To integrate collectively, in the context of a national program, the disciplines of engineering, epidemiology, medicine, biostatistics, public health, law and criminal justice, and behavioral and social sciences in order to prevent and control injuries more effectively; 4) To identify and evaluate current and new interventions for the prevention and control of injuries; 5) To bring the knowledge and expertise of ICRCs to bear on the development and improvement of effective public and private sector programs for injury prevention and control; and
6) To facilitate injury control efforts supported by various governmental agencies within a geographic region.

Grants for Academic Centers of Excellence for Youth Violence Prevention

The primary objectives of the Centers were to: 1) Build the scientific infrastructure necessary to support the development and widespread application of effective youth violence interventions, 2) promote interdisciplinary research strategies to address the problem of youth violence 3) foster collaboration between academic researchers and communities, and 4) empower communities to address the problem of youth violence. For the research component, centers could propose studies addressing the risk and protectives associated with youth violence as well as efficacy and effectiveness trials to prevent youth violence.

From: Frieden, Thomas (Tom) (CDC/OD)
Sent: Friday, April 15, 2016 4:37 PM
To: Payne, Rebecca L. (CDC/OD/OCS) <rco0@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>
Subject: Re: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

I don't have the annexes and question six implies recent funding in this area, is this the intent?

On Apr 15, 2016, at 4:22 PM, Payne, Rebecca L. (CDC/OD/OCS) <rco0@cdc.gov> wrote:

> Apologies for the quick turn around – if possible CDCW would like this to go out today. It has been reviewed by CDC, OFR, OADC, OADS, and OGC – including HHS OGC helping draft some portions of the response. You will see one edit from me in your cover letter that will be cleaned up but in the interest of time I am sending to you with the markup.
> We can go back to CDCW for more time but I should let them know by 5 if we think we need more time.
>
> **BLUF:** Senator Thomas Carper, Ranking Member of Homeland Security and Government Affairs, has written to the CDC Director to inquire about CDC's support for scientific research into the causes and prevention of gun violence gun violence.
>
> DRAFT
>
> [DATE]
>
> The Honorable Thomas R. Carper
> Ranking Member, Committee on Homeland Security
> and Governmental Affairs
> United States Senate
> Washington, DC 20510
> Dear Senator Carper:

Thank you for your letter regarding the status of the Centers for Disease Control and Prevention's (CDC) research into the causes and prevention of gun violence. CDC appreciates your concerns and those of the Committee on Homeland Security and Governmental Affairs, and is committed to protecting the health, safety, and security of the American people.

Enclosed, please find detailed responses to the specific questions outlined in your letter. We appreciate the Committee's interest in this important public health issue. If you have additional questions or concerns, please contact Cristi Schwarcz in the CDC Washington Office at Cschwarcz@cdc.gov or (202) 245-0600.

Sincerely,

Thomas R. Frieden, MD, MPH
Director, CDC
Enclosure

Centers for Disease Control and Prevention (CDC) Response to the Senate Committee on Homeland Security and Governmental Affairs regarding Gun Violence Research

1. **Please describe the CDC's policy toward scientific research into the causes and prevention of gun violence.**

   Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. While CDC's National Center for Injury Prevention and Control (NCIPC) has no specific program dedicated to firearm violence research and prevention, firearms are a mechanism (cause) of injury. Therefore, CDC addresses firearm-related violence prevention in the context of addressing related areas, including youth violence, child maltreatment, domestic violence, and sexual violence. These areas coincide with topical line items that are supported through CDC's annual appropriation for research and non-research activities. The Fiscal Year (FY) 2017 President's Budget includes $10 million to dedicate to gun violence prevention research.

2. **Has the CDC or the Department of Health and Human Services' (HHS) Office of the General Counsel conducted any analysis of the Dickey Amendment, including the types of gun violence research that are still permissible? If so, please provide this analysis.**

   In 1997, after the Dickey Amendment was passed, CDC interpreted the amendment as prohibiting impermissible lobbying related to advocating or promoting gun control. CDC also interpreted the amendment to mean that activities that supported the collection of firearm injury-related data and engagement in scientific, public health research directed to preventing injuries from violence and firearms were still permissible.

   More recently, in January 2013, the President issued a Presidential Memorandum, "Engaging in Public Health Research on the Causes and Prevention of Gun Violence" (Presidential Memorandum). This Presidential directive outlines the types of gun violence research that are permissible, including conducting or sponsoring research into the causes of gun violence and ways to prevent it, identifying the most pressing research questions with the greatest potential public health impact, and assessing existing public health interventions to prevent gun violence.

   The President's plan to reduce gun violence, "Now is the Time," also states that the language in the Dickey Amendment, limiting the use of appropriated funds to "advocate or promote gun control," does not bar CDC from conducting research on the causes of gun violence, noting specifically that "research on gun violence is not advocacy."

3. **In the aftermath of the shooting at Sandy Hook Elementary School in December 2012, President Obama issued a memorandum directing the Secretary of Health and Human Services (HHS), through the Director of the CDC and other agencies within HHS, to conduct or sponsor research**

into the causes of gun violence and the ways to prevent it. Please describe the efforts CDC has taken in response to this memorandum.

In January 2013, in response to the President's memorandum, CDC asked the Institute of Medicine (IOM), in collaboration with the National Research Council (NRC), to convene a committee to engage diverse stakeholders and identify the most pressing research questions on

gun violence, including those with the greatest potential public health impact. The IOM/NRC released their report, which is available at www.nationalacademies.org/hmd/Reports/2013/Priorities-for-Research-to-Reduce-the-Threat-of-Firearm-Related-Violence.aspx, on June 5, 2013. In addition, the CDC Foundation, in collaboration with CDC, commissioned the IOM/NRC to develop and disseminate three supplemental discussion papers focusing on youth possession and acquisition of firearms, the relationship between alcohol and firearm violence, and firearm access by persons at risk of harming themselves or others. These papers, available at www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Youth-Acquisition-Carrying-Firearms-US.pdf, www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Alcohol-Firearms.pdf, and www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Firearms-Suicide-Homicide.pdf, were released in late 2014.

In February 2014, CDC met with a number of Executive Branch agencies, including representatives from HHS and the Department of Justice, to discuss approaches for strengthening data to understand patterns and characteristics of firearm violence, address research questions identified in the IOM/NRC report, ensure that research carried out by the different agencies is complementary and builds upon individual and collective strengths, and determine opportunities to collaborate on current or future efforts. For examples of CDC investigations, analyses of surveillance, and other data to document the public health burden of firearm injuries, see **Appendix A**.

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   The President's FY 2017 Budget request includes $10 million in funding for gun violence prevention research. These funds would enable CDC to pursue research priorities identified in the IOM/NRC report.

   Should funding become available, CDC will pursue research activities that align with the priorities identified in the IOM/NRC report, *Priorities for Research to Reduce the Threat of Firearm-Related Violence* (available at www.nap.edu/read/18319/chapter/1). This includes understanding the characteristics of firearm violence (e.g., patterns of access and use among children and youth, and among high-risk racial/ethnic minority populations; rural/urban differences in firearm-related violence); the risk and protective factors for homicide and suicide firearm violence (e.g., alcohol, other situational or environmental factors; the factors influencing non-fatal firearm violence); and the effectiveness of interventions to prevent firearm violence (e.g., safe storage practices; whether existing evidence-based approaches and policies for preventing interpersonal violence are effective in reducing firearm-related deaths and injuries).

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6. **For each year from FY1996 to FY2015, what portion of the CDC's budget, including the budget of the National Center for Injury Prevention and Control, has been devoted to gun violence research?**

In FY 1997, Congress redirected $2.6 million from gun violence prevention activities to traumatic brain injury. CDC addresses firearm-related violence prevention in the context of other violence-related areas, including youth violence, child maltreatment, domestic violence, and sexual violence. These areas coincide with topical line items that are supported through CDC's annual appropriation for research and non-research activities. As previously noted, CDC has requested $10 million to dedicate to gun violence prevention research in the FY 2017 President's Budget.

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7. **Each year, CDC's Division of Violence Prevention solicits investigator-initiated research via an "RO1" Grant Program Announcement. The language in these announcements signals to grant-seeking public health researchers the research priorities of the CDC and its Division of Violence Prevention. Please describe any Division of Violence Prevention's RO1 Grant Program Announcements related to gun violence research put forward from 1996 to the present**.

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The research solicitations during these years focused on enhancing the understanding of social, economic, and environmental factors that may impact the frequency and severity of these forms of violence. The research solicitations also focused on enhancing evaluations of policies, programs, or other interventions that may reduce morbidity, mortality, and disabilities associated with suicidal behavior, assaultive violence, firearm-related injuries, intimate partner violence, and sexual violence. Researchers

proposed firearm-related research projects in the Injury Control Research Center (ICRC) grants and in the first cycle of funding for the Academic Centers of Excellence for Youth Violence Prevention (ACEs) during this period. The funding solicitations for the ICRCs and ACEs were broad and did not include specific priorities for firearm-related research. **See Appendix C**.

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grant/application writing, and/or state legislation that restricts sharing of data required for NVDRS.

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9. **Has the CDC previously entered into any agreements with the National Rifle Association offering to provide advanced notice of any publication on the subject of gun violence? If so, please provide a description of any such agreements as well as communications and documents memorializing the agreements.**

   CDC routinely informs stakeholder organizations, including the National Rifle Association, when articles of interest, such as articles on firearm-related violence, are released.

10. **From 1996 to the present, has the CDC instructed any employee or researcher to not conduct scientific research on gun violence? Has the CDC instructed any employees or researchers to re-write reports submitted for publication to avoid using any variation of the word "gun"?**

    CDC has not instructed employees or researchers to refrain from scientific research on gun violence. To ensure scientific integrity, technical accuracy, consistency with appropriations language, and usefulness to the intended audience, CDC has a standard agency review process for any manuscript or report produced by CDC scientists. Agency review is not specific to any topic area.

    In the course of reviewing manuscripts or reports on firearm violence, CDC has asked employees to use correct terminology—for example, to say "died as a result of a firearm-related injury" vs. "died from a firearm" in the same way as one would write "died as a result of a motor-vehicle crash" vs. "died from a car."

11. **What remedies are available to CDC researchers who believe their scientific research has been inappropriately suppressed or discouraged?**

Please describe any review or appeals processes and include a list of the offices or review boards who would address any such concerns.

CDC is committed to a transparent research process and works to conduct scientific research in a manner that increases our knowledge of public health and ensures scientific quality and integrity. As diligent stewards of the public funds entrusted to us, CDC programs work to ensure that our scientific efforts meet established public health goals. Working with their leadership, scientists and subject matter experts ensure accuracy, validity, and appropriateness of results and findings and follow best practices to assure scientific quality and integrity. CDC scientists are required to complete scientific integrity and quality training.

CDC has established an organizational framework that supports its scientists through the Associate Director for Science (ADS) structure. Through the ADS structure, CDC scientists can consult with their manager, leader, or ADS in their immediate program if they have concerns about research decisions. The ADS in the immediate program may escalate the matter to ADSs serving at higher organizational levels within the agency, as needed. Scientists may also escalate the matter to an ADS serving at higher organizational levels if they are in disagreement with the ADS in their immediate program or believe their research has been inappropriately discouraged.

To enhance the agency's strategic approach to scientific research, CDC also has established the Excellence in Science Committee (EISC). The EISC provides a forum for information exchange among CDC's ADSs. As an advocate for scientific quality and integrity, the EISC serves as a consulting body for science-related issues and makes recommendations when appropriate.

Contessa Dean
Public Health Analyst
Division of Issues Management, Analysis, and Coordination
Office of the Chief of Staff
1600 Clifton Road
Atlanta, Georgia 30329
404-639-7143
Cdd7@cdc.gov

<2353690 Carper Response- Gun Violence Draft v5 (003).docx>

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 18 Apr 2016 13:00:59 +0000
To: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);DVP Policy Requests (CDC)
Cc: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC);Cyril, Melissa R. (CDC/ONDIEH/NCIPC);Patterson, Sara S. (CDC/ONDIEH/NCIPC);Asekun, Adeyelu (CDC/ONDIEH/NCIPC);Reimels, Elizabeth (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC)
Subject: RE: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

Thanks. One thing I noticed:
Question 6 includes a point "As previously noted, CDC has requested $10 million to dedicate to gun violence prevention research in the FY 2017 President's Budget". The President has requested $10 million for the CDC to conduct research on gun violence. (b)(5)

(b)(5)

From: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC)
Sent: Monday, April 18, 2016 8:15 AM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) ; DVP Policy Requests (CDC)
Cc: Belser-Vega, Elizabeth (CDC/ONDIEH/NCIPC) ; Cyril, Melissa R. (CDC/ONDIEH/NCIPC) ; Patterson, Sara S. (CDC/ONDIEH/NCIPC) ; Asekun, Adeyelu (CDC/ONDIEH/NCIPC)
Subject: FYI: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690
FYI...this is the latest, final or very near final.

From: Hoffmann, Lauren (CDC/OD/OCS)
Sent: Monday, April 18, 2016 8:04 AM
To: Lubar, Debra (CDC/OCOO/OFR/OA) <dpl9@cdc.gov>; Patterson, Sara S. (CDC/ONDIEH/NCIPC) <afo0@cdc.gov>
Cc: Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Subject: FW: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690
Importance: High
Deb —I think Dr. Frieden is waiting for you to say that you are OK with the response for #6 and then he will clear. It was the only concern/question that he raised.
Sara—Attached is what we expect to be the final.
Lauren
Lauren Hoffmann, MA, BS I Lead, High Profile Action Team, Division of Issues Management, Analysis and Coordination (IMAC) I Office of Chief of Staff I Office of the Director I Centers for Disease Control and Prevention
1600 Clifton Road, NE, Atlanta, GA 30333 I Office: 404-639-7126 I Mobile: 404-547-3997 I E-mail: cpf5@cdc.gov
Forecast. Coordinate. Communicate.

From: Frieden, Thomas (Tom) (CDC/OD)
Sent: Friday, April 15, 2016 6:13 PM
To: Payne, Rebecca L. (CDC/OD/OCS) <rco0@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>; Lubar, Debra (CDC/OCOO/OFR/OA) <dpl9@cdc.gov>
Subject: RE: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

I'm ok w it if Deb is

From: Payne, Rebecca L. (CDC/OD/OCS)
Sent: Friday, April 15, 2016 5:03 PM
To: Frieden, Thomas (Tom) (CDC/OD) <txf2@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>; Lubar, Debra (CDC/OCOO/OFR/OA) <dpl9@cdc.gov>
Subject: RE: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

Re funding – we are being consistent with past statements and responses. The language you are asking about is consistent with responses we've sent to Congress via other inquiries. Our funded research in various violence related topic areas may touch on firearms even if it's not the full scope of the research. For example, the evaluation of Safe Streets, a violence interrupter program in Baltimore, would touch on firearm access and use even though the program isn't directly addressing firearms.
+Deb in case this raises additional questions

From: Payne, Rebecca L. (CDC/OD/OCS)
Sent: Friday, April 15, 2016 4:47 PM
To: Frieden, Thomas (Tom) (CDC/OD) <txf2@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>
Subject: RE: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

The appendices are in the end of the word doc but pasted the full doc below as well – we are checking on the funding q

The Honorable Thomas R. Carper
Ranking Member, Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Senator Carper:

Thank you for your letter regarding the status of the Centers for Disease Control and Prevention's (CDC) research into the causes and prevention of gun violence. CDC appreciates your concerns and those of the Committee on Homeland Security and Governmental Affairs, and is committed to protecting the health, safety, and security of the American people.

Enclosed, please find detailed responses to the specific questions outlined in your letter. We appreciate the Committee's interest in this important public health issue.

If you have additional questions or concerns, please contact Cristi Schwarcz in the CDC Washington Office at Cschwarcz@cdc.gov or (202) 245-0600.

Sincerely,

Thomas R. Frieden, MD, MPH
Director, CDC

Enclosure

Centers for Disease Control and Prevention (CDC) Response to the Senate Committee on Homeland Security and Governmental Affairs regarding Gun Violence Research

1. **Please describe the CDC's policy toward scientific research into the causes and prevention of gun violence.**

   Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. While CDC's National Center for Injury Prevention and Control (NCIPC) has no specific program dedicated to firearm violence research and prevention, firearms are a mechanism (cause) of injury. Therefore, CDC addresses firearm-related violence prevention in the context of addressing related areas, including youth violence, child maltreatment, domestic violence, and sexual violence. These areas coincide with topical line items that are supported through CDC's annual appropriation for research and non-research activities. The Fiscal Year (FY) 2017 President's Budget includes $10 million to dedicate to gun violence prevention research.

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a committee to engage diverse stakeholders and identify the most pressing research questions on

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The FY 2017 President's Budget includes $23.5 million in funding for the National Violent Death Reporting System. With the total request of $23.5 million, CDC will be able to complete the expansion of NVDRS to all 50 states and Washington, DC.

CDC expects that all states will apply for NVDRS funding should full funding be provided to support a national system. In FY 2016 and FY 2017, to prepare for additional expansion, CDC and our partners will continue to work with unfunded states to determine barriers related to collecting violent death data and develop strategies to address identified barriers. CDC has and will continue to collaborate with partners to provide training to previously unfunded states to offer guidance for implementing the system and for facilitating collaboration between previously unfunded states and experienced states.

9. **Has the CDC previously entered into any agreements with the National Rifle Association offering to provide advanced notice of any publication on the subject of gun violence? If so, please provide a description of any such agreements as well as communications and documents memorializing the agreements.**

   CDC routinely informs stakeholder organizations, including the National Rifle Association, when articles of interest, such as articles on firearm-related violence, are released.

10. **From 1996 to the present, has the CDC instructed any employee or researcher to not conduct scientific research on gun violence? Has the CDC instructed any employees or researchers to re-write reports submitted for publication to avoid using any variation of the word "gun"?**

    CDC has not instructed employees or researchers to refrain from scientific research on gun violence. To ensure scientific integrity, technical accuracy, consistency with appropriations language, and usefulness to the intended audience, CDC has a standard

agency review process for any manuscript or report produced by CDC scientists. Agency review is not specific to any topic area.

In the course of reviewing manuscripts or reports on firearm violence, CDC has asked employees to use correct terminology—for example, to say "died as a result of a firearm-related injury" vs. "died from a firearm" in the same way as one would write "died as a result of a motor-vehicle crash" vs. "died from a car."

11. **What remedies are available to CDC researchers who believe their scientific research has been inappropriately suppressed or discouraged? Please describe any review or appeals processes and include a list of the offices or review boards who would address any such concerns.**

CDC is committed to a transparent research process and works to conduct scientific research in a manner that increases our knowledge of public health and ensures scientific quality and integrity. As diligent stewards of the public funds entrusted to us, CDC programs work to ensure that our scientific efforts meet established public health goals. Working with their leadership, scientists and subject matter experts ensure accuracy, validity, and appropriateness of results and findings and follow best practices to assure scientific quality and integrity. CDC scientists are required to complete scientific integrity and quality training.

CDC has established an organizational framework that supports its scientists through the Associate Director for Science (ADS) structure. Through the ADS structure, CDC scientists can consult with their manager, leader, or ADS in their immediate program if they have concerns about research decisions. The ADS in the immediate program may escalate the matter to ADSs serving at higher organizational levels within the agency, as needed. Scientists may also escalate the matter to an ADS serving at higher organizational levels if they are in disagreement with the ADS in their immediate program or believe their research has been inappropriately discouraged.

To enhance the agency's strategic approach to scientific research, CDC also has established the Excellence in Science Committee (EISC). The EISC provides a forum for information exchange among CDC's ADSs. As an advocate for scientific quality and integrity, the EISC serves as a consulting body for science-related issues and makes recommendations when appropriate.

Appendix A – Examples of CDC firearm-related surveillance activities and analyses

Fowler KA, Dahlberg LL, Haileyesus T, Annest JL. Firearm injuries in the United States. Preventive Medicine 2015; 79:5-14.

Sullivan EM, Annest JL, Simon TR, Luo F, Dahlberg L. Suicide trends among persons aged 10–24 years — United States, 1994–2012. Morbidity and Mortality Weekly Report 2015; 64(08):201-205.

Kegler SR, Mercy JA. Firearm homicides and suicides in major metropolitan areas-United States, 2006-2007 and 2009-2010. Morbidity and Mortality Weekly Report 2013; 62(30):597-602.

Sullivan, E., Annest, J. L., Luo, F., Simon, T. R., & Dahlberg, L. L. Suicide among adults aged 35–64 years—United States, 1999–2010. Morbidity and Mortality Weekly Report, 2013; 62(17):321-325.

Ferdon CD, Dahlberg LL, Kegler S. Homicide rates among persons aged 10-24 years – United States, 1981-2010. Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, 2013; 62(27):545-548.

Egley A, Logan J, McDaniel D. Gang Homicides — Five U.S. Cities, 2003–2008. Morbidity and Mortality Weekly Report, 2012; 61(03):46-51.

Appendix B – CDC firearm-related research projects

Projects listed below were funded through the research grant programs, the Injury Control Research Centers (ICRC) and the first cycle of the Academic Centers of Excellence for Youth Violence Prevention (ACE).

Jeffrey Fagan
Situational Contexts of Gun and Non-Gun Injuries
R49/R01 1995-1997

Jeffrey Fagan
Lethal & Non-Lethal Adolescent Violence: Social, Economic, & Neighborhood
R49/R01 1996-1998

David McDowall
Injury Prevention Effects of Violence Interventions
R49/R01 1996-1998

David Grossman
Firearm Storage Device Evaluation
R49/R01 1998-2000

David Hemenway
Adult Firearms Survey
ICRC 1998-2001 (Harvard)

Daniel Webster
Understanding risks for retaliatory shootings and opportunities for prevention
ICRC 1999-2000 (Hopkins)

Daniel Webster
Estimating the effects of laws setting minimum legal age for handgun purchase and possession on youth suicide and homicide
ACE 2000-2005

David Hemenway
Evaluation of State-Level Firearms Policies
ICRC 2001-2006 (Harvard)

Appendix C – Research solicitations

A synopsis of firearm-related funding announcements, from 1996-2001, within the context of addressing assaultive behavior among youth, suicidal behavior, intimate partner violence and sexual violence, is provided below.

1996

FOA# CE96-011 Grants for Violence-Related Injury Prevention Research

Grant applicants should concentrate on the need to reduce morbidity, mortality, and disabilities caused by suicidal behavior, assaultive behavior among youth, and family and intimate partner violence.

1. Injury from Suicidal and Assaultive Behavior

Enhancing our understanding of social, economic, and environmental factors that may affect suicidal behavior:

- Study how choice of method (firearm, overdosing, etc.) in planning or attempting suicidal behavior is influenced by cultural, social, or environmental factors.
- Conduct research to determine the nature of suicide risk among gay and lesbian persons in comparison to the general population.
- Evaluate policies, programs, or interventions that may reduce suicidal behavior via the modification of social, economic, or environmental circumstances.
- Assess the effectiveness of interventions that attempt to remove access to lethal means in reducing injury and severity of injury from suicidal behavior.

Enhancing our understanding of the importance of social and economic factors that influence assaultive behavior among youth:

- Study why many socioeconomically disadvantaged youth do not engage in assaultive behavior despite their socioeconomic status.
- Undertake research to increase our understanding of relationships between poverty and assaultive behavior among youth.
- Study how unequal access to criminal justice, health care, and educational systems is related to assaultive behavior.
- Evaluate policies, programs, or interventions that may reduce assaultive behavior among youth via the modification of social or economic circumstances.

2. Family and Intimate Violence Prevention

Address and define the needs of mothers and children in families where intimate violence occurs.

- Undertake research to determine effective interventions for mothers and children in families with ongoing violence
- Conduct studies to determine which mothers and children are most likely to be helped by interventions designed for families with ongoing violence
- Examine variables related to mothers, children, and families that may predict intervention effectiveness
- Conduct studies related to the impact of children witnessing violence in their families.

Define the incidence or prevalence of functional limitations and disabilities among women as a result of intimate partner violence.

- Quantify injuries sustained (nature and severity) and subsequent short and long-term (1-year) functional limitations and disability
- Quantify the use of acute care, mental health, rehabilitation, and social services

- Identify risk factors for adverse outcomes

1998

FOA# CE98-029 Grants for Violence-Related Injury Prevention Research

Grant applicants should concentrate on the need to reduce morbidity, mortality, and disabilities caused by suicidal behavior, firearm-related injury, sexual violence, or intimate partner violence.

1. *Injury prevention research addressing emerging issues in suicidal behavior*
   - Conduct research to develop and improve measurement instruments for the identification and study of suicides and suicide attempts in surveys, research studies, and surveillance systems.
   - Conduct research designed to improve understanding of the nature of suicide risk among emerging high-risk populations such as young African American males.
   - Conduct research that further illuminates understanding of the contribution of potential risk factors for suicide such as impulsivity, sexual orientation, and hopelessness.
2. *Injury prevention research addressing firearm-related injuries among children and adolescents*
   - Conduct research to improve understanding of the motivations and deterrents for weapon carrying behavior among adolescents at high risk for firearm-related injuries.
   - Conduct research that estimates injury risk associated with firearm storage or carriage practices.
   - Conduct research that addresses the effects of firearm safety training and education programs on firearm storage and carriage practices.
3. *Injury prevention research addressing sexual violence or intimate partner violence*
   - Conduct research to address the impact of welfare and welfare-to-work programs on women (and their children) who experience intimate partner violence.
   - Conduct research to determine the effectiveness of prevention programs for adolescent males at risk for perpetration of sexual violence or intimate partner violence or intervention programs for perpetrators of sexual violence or intimate partner violence.
   - Conduct research on risk factors for perpetration of sexual violence.

1999

FOA# CE99-055 Extramural Grants for Violence-Related Injury Evaluation Research

The purposes of this program are to: evaluate the effectiveness and/or cost effectiveness of interventions and policies designed to reduce morbidity, mortality, and disabilities caused by suicidal behavior, firearm-related injury, sexual violence, or intimate partner violence.

1. In the area of suicide, there is particular interest in projects to evaluate suicide prevention interventions for general or high risk populations and projects to evaluate services provided in various settings such as a managed care setting.
2. In the area of firearm injuries, there is particular interest in projects evaluating prevention programs and policies that offer promise in preventing firearm injuries among children and adolescents (e.g., safe storage of firearms in homes, safe gun technology, curricula to promote gun safety for children and adolescents).

3. In the areas of sexual violence and intimate partner violence, there is particular interest in evaluation research to determine the effectiveness of:
    - Prevention programs for adolescent males at risk for perpetration of sexual violence or intimate partner violence; or
    - Intervention programs for perpetrators of sexual violence or intimate partner violence.

2001

FOA# CE01-016 Grants for Violence-Related Injury Prevention Research

Research is sought to better understand the etiology of violence and its consequences, to determine how best to prevent violence-related injury among different segments of the population and in different settings, and how best to reduce the severity of the emotional and physical consequences of violence.

1. *Improve understanding of the etiology of violence (i.e., interpersonal youth violence, child abuse, intimate partner violence, suicide, and sexual assault) and its consequences through research that addresses:*
    - The independent, additive, interactive, and sequential effects of psychological, socioeconomic, and environmental risk and protective factors.
    - Factors that have differential effects on the onset, persistence, escalation, de-escalation, or desistance of violent offending at different ages.
    - Factors that increase the severity of the emotional and physical consequences of violence and suicidal behavior.
    - The effect of social and economic risk and protective factors such as poverty, social contagion, social norms, and social capital on interpersonal violence.
    - The effect of psychological, social, and environmental factors not directly related to mental health on suicide.
    - The risks and benefits of firearm access or carrying.
2. *Improve understanding of the relationships between different types of violence. of particular concern are:*
    - The relationship between intimate partner violence victimization and perpetration to child abuse.
    - The effects of exposure to child abuse and intimate partner violence on suicidal behavior.
    - The effects of witnessing violence as a child in the home and community on violent behavior during adolescence and adulthood.
3. *Design and test preventive interventions for intimate partner violence, sexual violence, suicidal behavior, and child abuse.*
4. *Evaluate the feasibility and impact of screening and intervention methods in the acute medical care setting for youth interpersonal violence, child abuse, suicidal ideation, and intimate partner violence.*
5. *Advance our understanding of the effectiveness of interventions to prevent youth violence by evaluating:*
    - The long-term impact of promising interventions.
    - Multifaceted interventions to prevent youth violence.
    - The effect youth-violence-prevention strategies in diverse cultural and social settings.

- The cost effectiveness of promising interventions

_____
2015

FOA# CE15-001 Research Grants for Preventing Violence and Violence-Related Injury

NCIPC is soliciting investigator-initiated research that will help expand and advance knowledge in three areas: (1) how best to disseminate, implement, and translate evidence-based primary prevention strategies, programs and policies designed to reduce youth violence; (2) what works to prevent violence by rigorously evaluating primary prevention strategies, programs, and policies; and (3) research to determine ways to effectively prevent serious and lethal interpersonal and self-directed violence. The following research objectives are the focus of this announcement:

1. *Research to prevent youth violence:*
   - Dissemination/implementation/translation research to accelerate the adoption of evidence-based strategies, programs, and policies to prevent youth violence. There is particular interest in research that examines how models that have shown preventive effects on violence outcomes at the community level (e.g., Communities That Care, Cardiff Violence Prevention Program) can be adopted for use in high risk communities. Prevention models that bring together different sectors within communities to make data driven decisions about the set of evidence-based prevention activities that are most appropriate for the local community and then ensure implementation of those strategies have the potential to reduce risk for violence at the community level. Additional research is needed to help communities understand the capacity needed to implement these models, how the models can be appropriately adopted, and the effects of modifications on violence outcomes.
   - Effectiveness research to determine which community-level and societal-level strategies, programs, and policies effectively prevent youth violence. This includes studies to assess the effectiveness of economic development schemes (e.g., business improvement districts) and other efforts to improve the physical, social, and economic characteristics of neighborhoods; and the effectiveness of strategies aimed at reducing the level and concentration of community risk factors. There is also interest in the area of youth violence to assess the economic efficiency of strategies, programs and policies designed to prevent youth violence.
   - Effectiveness research to prevent serious and lethal violence among youth. Although there is a strong and growing evidence-base to prevent youth violence (e.g., universal school-based programs, parent/family focused interventions), there is less evidence addressing the more serious forms of violence among youth. Research is needed to determine ways to effectively prevent serious and lethal violence involving youth, particularly identifying and evaluating strategies addressing the leading mechanisms of youth homicide and assault-related injuries.
2. *Research to prevent teen dating violence, intimate partner violence, and sexual violence:*
   - Within the context of teen dating violence, intimate partner and sexual violence, there is interest in assessing the efficacy/effectiveness of primary prevention strategies aimed at preventing the initial perpetration of violence and promoting respectful, nonviolent relationships.6 Intervening in ways that prevent the initial perpetration of violence, that alter developmental trajectories leading to initial perpetration of violence, and that

promote an environment of nonviolence and respect is key to eliminating sexual and intimate partner violence.

- Effectiveness research to determine which community-level and societal-level strategies, programs, and policies effectively prevent teen dating violence, intimate partner and sexual
  violence. This includes studies to assess the effectiveness of economic schemes (e.g., microfinance, business improvement districts) and other efforts to improve the physical, social,
  and economic characteristics of neighborhoods and other settings; studies to assess the effectiveness of social and cultural norm change strategies at the community and societal level aimed at changing social contexts that condone or tolerate aggression and perpetration; and the effectiveness of strategies aimed at reducing the level and concentration of community risk factors.
- There is also interest in studies to assess the effectiveness of programs, policies, or strategies to prevent injuries and deaths in the context of teen dating violence and intimate partner violence. Women are much more likely than men to be injured or killed in incidents of violence between intimate partners. Research is needed to determine ways to effectively prevent serious and lethal violence against intimate partners, particularly identifying and evaluating strategies addressing the leading mechanisms of intimate partner homicide.

3. *Research to prevent suicidal behavior:*

- In the area of suicidal behavior, there is interest in efficacy/effectiveness studies of social, economic, and environmental primary prevention strategies to prevent suicidal behavior, including strategies aimed at enhancing connectedness for groups at high-risk for suicidal behavior and community-level efforts to reduce social isolation and stigma associated with seeking help for personal crises. There is also interest in studies to determine whether evidence-based programs for other forms of violence can also prevent suicidal behavior. Suicidal behavior and interpersonal violence share a number of risk and protective factors. However, only a limited number of evaluations of strategies that have demonstrated reductions in interpersonal violence have examined the impact of these strategies on suicidal behavior.
- There is also interest in studies assessing the effectiveness of programs, policies, and other intervention strategies to reduce access to lethal means. Research indicates that the means used in suicidal behavior (e.g., jumping from a bridge, hanging or suffocation versus taking pills) has a substantial impact on whether the act results in significant injury or death. Strategies related to means restriction, however, have rarely been rigorously evaluated particularly for their impact and feasibility for broader implementation. Knowledge is also limited regarding the effects of means restriction on different age groups, and how means substitution (i.e., switching from one suicide method to another) will limit the effectiveness of means-restriction strategies.

Grants for Injury Control Research Centers (ICRCs)

The purposes of this program are: 1) To support injury prevention and control research on priority issues as delineated in: Healthy People 2000; Injury Control in the 1990's: A National Plan for Action; Injury in America; Injury Prevention: Meeting the Challenge; and Cost of

Injury: A Report to the Congress; 2) To support ICRCs which represent CDC's largest national extramural investment in injury control research and training, intervention development, and evaluation; 3) To integrate collectively, in the context of a national program, the disciplines of engineering, epidemiology, medicine, biostatistics, public health, law and criminal justice, and behavioral and social sciences in order to prevent and control injuries more effectively; 4) To identify and evaluate current and new interventions for the prevention and control of injuries; 5) To bring the knowledge and expertise of ICRCs to bear on the development and improvement of effective public and private sector programs for injury prevention and control; and
6) To facilitate injury control efforts supported by various governmental agencies within a geographic region.

Grants for Academic Centers of Excellence for Youth Violence Prevention

The primary objectives of the Centers were to: 1) Build the scientific infrastructure necessary to support the development and widespread application of effective youth violence interventions, 2) promote interdisciplinary research strategies to address the problem of youth violence 3) foster collaboration between academic researchers and communities, and 4) empower communities to address the problem of youth violence. For the research component, centers could propose studies addressing the risk and protectives associated with youth violence as well as efficacy and effectiveness trials to prevent youth violence.

From: Frieden, Thomas (Tom) (CDC/OD)
Sent: Friday, April 15, 2016 4:37 PM
To: Payne, Rebecca L. (CDC/OD/OCS) <rco0@cdc.gov>
Cc: Villar, Carmen S. (CDC/OD/OCS) <coh2@cdc.gov>; Hoffmann, Lauren (CDC/OD/OCS) <cpf5@cdc.gov>; Richards, Bridget (CDC/OD/OCS) (CTR) <hjx0@cdc.gov>
Subject: Re: URGENT FOR APPROVAL: Support for Gun Violence Research - Senator Thomas Carper - Folder 2353690

I don't have the annexes and question six implies recent funding in this area, is this the intent?

On Apr 15, 2016, at 4:22 PM, Payne, Rebecca L. (CDC/OD/OCS) <rco0@cdc.gov> wrote:

> Apologies for the quick turn around – if possible CDCW would like this to go out today. It has been reviewed by CDC, OFR, OADC, OADS, and OGC – including HHS OGC helping draft some portions of the response. You will see one edit from me in your cover letter that will be cleaned up but in the interest of time I am sending to you with the markup.
> We can go back to CDCW for more time but I should let them know by 5 if we think we need more time.
>
> **BLUF:** Senator Thomas Carper, Ranking Member of Homeland Security and Government Affairs, has written to the CDC Director to inquire about CDC's support for scientific research into the causes and prevention of gun violence gun violence.
>
> DRAFT
>
> [DATE]
>
> The Honorable Thomas R. Carper
> Ranking Member, Committee on Homeland Security
> and Governmental Affairs
> United States Senate
> Washington, DC 20510
> Dear Senator Carper:

Thank you for your letter regarding the status of the Centers for Disease Control and Prevention's (CDC) research into the causes and prevention of gun violence. CDC appreciates your concerns and those of the Committee on Homeland Security and Governmental Affairs, and is committed to protecting the health, safety, and security of the American people.

Enclosed, please find detailed responses to the specific questions outlined in your letter. We appreciate the Committee's interest in this important public health issue. If you have additional questions or concerns, please contact Cristi Schwarcz in the CDC Washington Office at Cschwarcz@cdc.gov or (202) 245-0600.

Sincerely,

Thomas R. Frieden, MD, MPH
Director, CDC
Enclosure

Centers for Disease Control and Prevention (CDC) Response to the Senate Committee on Homeland Security and Governmental Affairs regarding Gun Violence Research

1. **Please describe the CDC's policy toward scientific research into the causes and prevention of gun violence.**

   Understanding the patterns, characteristics, and impact of firearm violence is an important step toward preventing firearm injuries and deaths in the United States. While CDC's National Center for Injury Prevention and Control (NCIPC) has no specific program dedicated to firearm violence research and prevention, firearms are a mechanism (cause) of injury. Therefore, CDC addresses firearm-related violence prevention in the context of addressing related areas, including youth violence, child maltreatment, domestic violence, and sexual violence. These areas coincide with topical line items that are supported through CDC's annual appropriation for research and non-research activities. The Fiscal Year (FY) 2017 President's Budget includes $10 million to dedicate to gun violence prevention research.

2. **Has the CDC or the Department of Health and Human Services' (HHS) Office of the General Counsel conducted any analysis of the Dickey Amendment, including the types of gun violence research that are still permissible? If so, please provide this analysis.**

   In 1997, after the Dickey Amendment was passed, CDC interpreted the amendment as prohibiting impermissible lobbying related to advocating or promoting gun control. CDC also interpreted the amendment to mean that activities that supported the collection of firearm injury-related data and engagement in scientific, public health research directed to preventing injuries from violence and firearms were still permissible.

   More recently, in January 2013, the President issued a Presidential Memorandum, "Engaging in Public Health Research on the Causes and Prevention of Gun Violence" (Presidential Memorandum). This Presidential directive outlines the types of gun violence research that are permissible, including conducting or sponsoring research into the causes of gun violence and ways to prevent it, identifying the most pressing research questions with the greatest potential public health impact, and assessing existing public health interventions to prevent gun violence.

   The President's plan to reduce gun violence, "Now is the Time," also states that the language in the Dickey Amendment, limiting the use of appropriated funds to "advocate or promote gun control," does not bar CDC from conducting research on the causes of gun violence, noting specifically that "research on gun violence is not advocacy."

3. **In the aftermath of the shooting at Sandy Hook Elementary School in December 2012, President Obama issued a memorandum directing the Secretary of Health and Human Services (HHS), through the Director of the CDC and other agencies within HHS, to conduct or sponsor research**

into the causes of gun violence and the ways to prevent it. Please describe the efforts CDC has taken in response to this memorandum.

In January 2013, in response to the President's memorandum, CDC asked the Institute of Medicine (IOM), in collaboration with the National Research Council (NRC), to convene a committee to engage diverse stakeholders and identify the most pressing research questions on

gun violence, including those with the greatest potential public health impact. The IOM/NRC released their report, which is available at www.nationalacademies.org/hmd/Reports/2013/Priorities-for-Research-to-Reduce-the-Threat-of-Firearm-Related-Violence.aspx, on June 5, 2013. In addition, the CDC Foundation, in collaboration with CDC, commissioned the IOM/NRC to develop and disseminate three supplemental discussion papers focusing on youth possession and acquisition of firearms, the relationship between alcohol and firearm violence, and firearm access by persons at risk of harming themselves or others. These papers, available at www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Youth-Acquisition-Carrying-Firearms-US.pdf, www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Alcohol-Firearms.pdf, and www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/2014-DEC-18/Firearms-Suicide-Homicide.pdf, were released in late 2014.

In February 2014, CDC met with a number of Executive Branch agencies, including representatives from HHS and the Department of Justice, to discuss approaches for strengthening data to understand patterns and characteristics of firearm violence, address research questions identified in the IOM/NRC report, ensure that research carried out by the different agencies is complementary and builds upon individual and collective strengths, and determine opportunities to collaborate on current or future efforts. For examples of CDC investigations, analyses of surveillance, and other data to document the public health burden of firearm injuries, see **Appendix A**.

In FY 2015, with increased appropriations, CDC expanded the National Violent Death Reporting System (NVDRS) from 18 to 32 participating states. In FY16, utilizing increased appropriation ($4.7 million), CDC plans to expand the NVDRS to an additional four to seven states. NVDRS is a state-based surveillance system that pools information about the "who, when, where, and how" from data on violent deaths to provide insights on "why" they occur. It gives states and communities a clearer understanding of violent deaths to guide local decisions about efforts to prevent violence and track progress over time. Findings from NVDRS have resulted in tailored interventions, including increased veterans services to prevent suicide, ensuring child witnesses of domestic violence homicides are linked to social services, and screening older adults for depression.

4. **In April 2013, the National Center for Injury Prevention and Control asked the Institute of Medicine to recommend a research agenda on the public health aspects of firearm-related violence. Please describe the actions the CDC plans to take in response to the findings of the Institute of Medicine report issued in June 2013.**

   The President's FY 2017 Budget request includes $10 million in funding for gun violence prevention research. These funds would enable CDC to pursue research priorities identified in the IOM/NRC report.

   Should funding become available, CDC will pursue research activities that align with the priorities identified in the IOM/NRC report, *Priorities for Research to Reduce the Threat of Firearm-Related Violence* (available at www.nap.edu/read/18319/chapter/1). This includes understanding the characteristics of firearm violence (e.g., patterns of access and use among children and youth, and among high-risk racial/ethnic minority populations; rural/urban differences in firearm-related violence); the risk and protective factors for homicide and suicide firearm violence (e.g., alcohol, other situational or environmental factors; the factors influencing non-fatal firearm violence); and the effectiveness of interventions to prevent firearm violence (e.g., safe storage practices; whether existing evidence-based approaches and policies for preventing interpersonal violence are effective in reducing firearm-related deaths and injuries).

5. **From 1996 to the present, please describe notable examples of research conducted or funded by the CDC, including research by or through the National Center for Injury Prevention and Control, related to understanding gun violence.**

   For a list of projects funded through the research grant programs, the Injury Control Research Centers (ICRC), and the first cycle of the Academic Centers of Excellence for Youth Violence Prevention (ACE), please see **Appendix B**.

   5a. Please also provide all instances when the CDC included requests for gun violence research in its research proposal solicitation materials.

   Firearm-related research priorities were included in funding solicitations from 1996-2001 within the context of addressing assaultive behavior among youth, suicidal behavior, intimate partner violence and sexual violence. The funding solicitations for the ICRCs and ACEs were broad and did not include specific priorities for firearm-related research. For a list of these funding announcements, please see **Appendix C**.

6. **For each year from FY1996 to FY2015, what portion of the CDC's budget, including the budget of the National Center for Injury Prevention and Control, has been devoted to gun violence research?**

In FY 1997, Congress redirected $2.6 million from gun violence prevention activities to traumatic brain injury. CDC addresses firearm-related violence prevention in the context of other violence-related areas, including youth violence, child maltreatment, domestic violence, and sexual violence. These areas coincide with topical line items that are supported through CDC's annual appropriation for research and non-research activities. As previously noted, CDC has requested $10 million to dedicate to gun violence prevention research in the FY 2017 President's Budget.

Because firearms are a cause of injuries in these related areas, CDC has awarded research grants that address firearms as part of their scope, based on a competitive process. Proposals are evaluated for scientific and technical merit by an external peer review group, in accordance with CDC peer review policy and procedures, using stated review criteria. Since awards are competitive, the funding levels for firearm-related activities from 1997 through 2015 have ranged from about $100,000 to just over $1 million. Comparisons to the total NCIPC budget or total CDC budget are not informative because the agency's budget structure and scope have changed dramatically in the past 20 years.

7. **Each year, CDC's Division of Violence Prevention solicits investigator-initiated research via an "RO1" Grant Program Announcement. The language in these announcements signals to grant-seeking public health researchers the research priorities of the CDC and its Division of Violence Prevention. Please describe any Division of Violence Prevention's RO1 Grant Program Announcements related to gun violence research put forward from 1996 to the present**.

Firearm-related research priorities were included in funding solicitations from 1996-2001 within the context of addressing assaultive behavior among youth, suicidal behavior, intimate partner violence, and sexual violence. All R01applications were evaluated for scientific and technical merit by an external peer review group, in accordance with CDC peer review policy and procedures, using stated review criteria. Following initial peer review, recommended applications received a second level of review. A variety of factors were considered in making funding decisions, such as scientific and technical merit of the proposed project as determined by scientific peer review, availability of funds, and relevance of the proposed projects to program priorities.

The research solicitations during these years focused on enhancing the understanding of social, economic, and environmental factors that may impact the frequency and severity of these forms of violence. The research solicitations also focused on enhancing evaluations of policies, programs, or other interventions that may reduce morbidity, mortality, and disabilities associated with suicidal behavior, assaultive violence, firearm-related injuries, intimate partner violence, and sexual violence. Researchers

proposed firearm-related research projects in the Injury Control Research Center (ICRC) grants and in the first cycle of funding for the Academic Centers of Excellence for Youth Violence Prevention (ACEs) during this period. The funding solicitations for the ICRCs and ACEs were broad and did not include specific priorities for firearm-related research. **See Appendix C**.

The funding priorities for the R01 investigator-initiated research grants from 2002-2012 emphasized dissemination research and effectiveness research, particularly the effectiveness of primary prevention strategies to prevent child maltreatment, intimate partner violence, sexual violence, youth violence, and suicidal behavior. The research objectives outlined in Funding Opportunity Announcements are based on priorities in the NCIPC Research Agenda.

8. **The National Violent Death Reporting System collects and combines data from multiple sources to provide states and communities with a more complete record of the circumstances surrounding violent deaths. Participation from all 50 states would significantly increase the amount of data available to the National Violent Death Reporting System and, thereby, improve its effectiveness. In how many states has the National Violent Death Reporting System been implemented?**

NVDRS has been implemented in 32 states, and with the FY2016 appropriations increase, the system will expand to include an additional four to seven states. The funding announcement was recently released, and states' applications are due to CDC on May 27. Final funding decisions will be made by September. CDC has requested an increase of $7.6 million in FY 2017 in order to support NVDRS nationwide.

8a. How many states have applied to be included in this system?

Over the years, 41 states have applied to the NVDRS funding opportunity announcements. This year, 18 states and Washington, DC, are eligible to apply. The remaining 32 states are funded for multiple years. Therefore, they are not eligible to apply this year.

8b. What circumstances have prevented all state applicants from being added to the National Violent Death Reporting System?

Currently, NVDRS does not include all state applicants because levels of funding are not sufficient to support every state. Therefore, all prior funding opportunity announcements for NVDRS have been competitive. Based on objective reviews, criteria for not funding prior applicants include lack of an injury prevention (or other suitable public health) infrastructure to provide adequate staffing and resources, inability to develop or demonstrate partnerships with data providers (vital registrars, coroners/medical examiners, or law enforcement) required for NVDRS, problems with

grant/application writing, and/or state legislation that restricts sharing of data required for NVDRS.

The FY 2017 President's Budget includes $23.5 million in funding for the National Violent Death Reporting System. With the total request of $23.5 million, CDC will be able to complete the expansion of NVDRS to all 50 states and Washington, DC.

CDC expects that all states will apply for NVDRS funding should full funding be provided to support a national system. In FY 2016 and FY 2017, to prepare for additional expansion, CDC and our partners will continue to work with unfunded states to determine barriers related to collecting violent death data and develop strategies to address identified barriers. CDC has and will continue to collaborate with partners to provide training to previously unfunded states to offer guidance for implementing the system and for facilitating collaboration between previously unfunded states and experienced states.

9. **Has the CDC previously entered into any agreements with the National Rifle Association offering to provide advanced notice of any publication on the subject of gun violence? If so, please provide a description of any such agreements as well as communications and documents memorializing the agreements.**

   CDC routinely informs stakeholder organizations, including the National Rifle Association, when articles of interest, such as articles on firearm-related violence, are released.

10. **From 1996 to the present, has the CDC instructed any employee or researcher to not conduct scientific research on gun violence? Has the CDC instructed any employees or researchers to re-write reports submitted for publication to avoid using any variation of the word "gun"?**

    CDC has not instructed employees or researchers to refrain from scientific research on gun violence. To ensure scientific integrity, technical accuracy, consistency with appropriations language, and usefulness to the intended audience, CDC has a standard agency review process for any manuscript or report produced by CDC scientists. Agency review is not specific to any topic area.

    In the course of reviewing manuscripts or reports on firearm violence, CDC has asked employees to use correct terminology—for example, to say "died as a result of a firearm-related injury" vs. "died from a firearm" in the same way as one would write "died as a result of a motor-vehicle crash" vs. "died from a car."

11. **What remedies are available to CDC researchers who believe their scientific research has been inappropriately suppressed or discouraged?**

Please describe any review or appeals processes and include a list of the offices or review boards who would address any such concerns.

CDC is committed to a transparent research process and works to conduct scientific research in a manner that increases our knowledge of public health and ensures scientific quality and integrity. As diligent stewards of the public funds entrusted to us, CDC programs work to ensure that our scientific efforts meet established public health goals. Working with their leadership, scientists and subject matter experts ensure accuracy, validity, and appropriateness of results and findings and follow best practices to assure scientific quality and integrity. CDC scientists are required to complete scientific integrity and quality training.

CDC has established an organizational framework that supports its scientists through the Associate Director for Science (ADS) structure. Through the ADS structure, CDC scientists can consult with their manager, leader, or ADS in their immediate program if they have concerns about research decisions. The ADS in the immediate program may escalate the matter to ADSs serving at higher organizational levels within the agency, as needed. Scientists may also escalate the matter to an ADS serving at higher organizational levels if they are in disagreement with the ADS in their immediate program or believe their research has been inappropriately discouraged.

To enhance the agency's strategic approach to scientific research, CDC also has established the Excellence in Science Committee (EISC). The EISC provides a forum for information exchange among CDC's ADSs. As an advocate for scientific quality and integrity, the EISC serves as a consulting body for science-related issues and makes recommendations when appropriate.

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<2353690 Carper Response- Gun Violence Draft v5 (003).docx>

From: Young, Belinda R. (CDC/ONDIEH/NCCDPHP) (CTR)
Sent: 25 Jul 2016 10:57:51 -0400
To: Wilkins, Natalie J. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Davis, Shane P. (CDC/ONDIEH/NCIPC);Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Subject: RE: What's new for 'schools violence prevention' in PubMed

This is really interesting Natalie. I do think that this is relevant to the study. Thanks for sharing!

From: Wilkins, Natalie J. (CDC/ONDIEH/NCIPC)
Sent: Monday, July 25, 2016 9:15 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Davis, Shane P. (CDC/ONDIEH/NCIPC) ; Young, Belinda R. (CDC/ONDIEH/NCCDPHP) (CTR) ; Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Subject: FW: What's new for 'schools violence prevention' in PubMed

Hi all- FYI, this seems potentially related to the GVRO study work going on in CA.

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From: Hertz, Marci F. (CDC/ONDIEH/NCIPC)
Sent: Monday, July 25, 2016 8:23 AM
To: Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC) <dcz0@cdc.gov>; McClure, Roderick J. (CDC/ONDIEH/NCIPC) <xhd4@cdc.gov>; Wilkins, Natalie J. (CDC/ONDIEH/NCIPC) <hux9@cdc.gov>
Cc: Newton, Donovan (CDC/ONDIEH/NCIPC) <ime1@cdc.gov>
Subject: FW: What's new for 'schools violence prevention' in PubMed

FYI, saw this abstract below and thought you might be interested in the article text (I can't save the pdf version for some reason):

California approves publicly funded gun research center

Emily Underwood

Science 24 Jun 2016:
Vol. 352, Issue 6293, pp. 1505
DOI: 10.1126/science.352.6293.1505

For 2 decades, firearm advocates in Congress have blocked taxpayer-funded research into the causes and consequences of gun violence, which kills more people in the United States than in any other developed nation. Last week, California's state legislature bucked that trend, voting to establish the nation's first publicly funded center for studying gun violence.

The new California Firearm Violence Research Center will be run by the University of California (UC) system. Its lean budget—$1 million per year over the next 5 years—will likely preclude large-scale studies, but backers hope it will demonstrate the value of publicly funded gun research and perhaps help build support in Congress for a similar federal effort. The 16 June vote to create the center poses "a very stark" contrast to the continuing gridlock in Congress, says epidemiologist Garen Wintemute, who studies firearm violence at UC Davis. Last fall, he worked with state Senator Lois Wolk (D) to develop plans for the center.

Coincidentally, the California vote came just 4 days after a gunman killed 49 people and injured 53 at a gay nightclub in Orlando, Florida, sparking renewed debate in Congress over proposals to impose new federal rules on gun purchases. Events like the Orlando massacre—one of the country's worst mass shootings—"leave us searching for answers," Wolk said in a statement. "We know that using real data and scientific methods, our best researchers can help policy makers get past the politics and find real answers to this public health crisis."

"This shows the kind of thing states can do" in the absence of federal action, says David Hemenway, a health policy researcher at Harvard University. In 1996, the National Rifle Association and other groups successfully lobbied Congress to stifle federally funded gun research. Led by then-Representative Jay Dickey (R–AR), lawmakers barred the U.S. Centers for Disease Control and Prevention from funding any activity that would "advocate or promote gun control" and eliminated a $2.5 million pot of money for gun-related studies.

Dickey, now retired, has since reversed his position and advocates for more gun research. But the lack of public funding means that few young scientists are drawn to the field, says Wintemute, who has spent more than $1 million of his own funds to sustain his research.

The new center will focus on interdisciplinary research "to provide the scientific evidence upon which to base sound firearm violence prevention policies and programs," according to Wolk. "You name it, we need to know about it," says Hemenway, citing the need for more information on everything from firearm training and gun thefts to their role in suicide and homicide.

Wintemute adds that the center could enable a small team of researchers to examine California's unique data set on statewide gun transfers and other firearm-related activities. One pressing question, he says, is why California's annual fatalities from gun violence have dropped by roughly 20% since 2000, even as the nationwide rate has not changed. "We don't know why that is," Wintemute says. "Are we doing something right? Or are we not doing something wrong that other [states] are?"

The location of the new center is not yet "locked in," but Wintemute believes UC Davis is the most likely candidate. And he hopes the state funding will help researchers attract additional money from private donors.

From: My NCBI [mailto:efback@ncbi.nlm.nih.gov]
Sent: Friday, July 22, 2016 6:19 AM
To: Hertz, Marci F. (CDC/ONDIEH/NCIPC) <mvf4@cdc.gov>
Subject: What's new for 'schools violence prevention' in PubMed

This message contains My NCBI what's new results from the National Center for Biotechnology Information (NCBI) at the U.S. National Library of Medicine (NLM).
Do not reply directly to this message.

Sender's message: Search: schools violence prevention

Sent on Friday, 2016 July 22
Search: **schools violence prevention**

View complete results in PubMed (results may change over time).

Edit saved search settings, or unsubscribe from these e-mail updates.

PubMed Results

Item 1 of 1
1. PUBLIC HEALTH. California approves publicly funded gun research center.
Underwood E.

Science. 2016 Jun 24;352(6293):1505. doi: 10.1126/science.352.6293.1505. No abstract available.
PMID: 27339962 [PubMed - indexed for MEDLINE]
Similar articles

    - There are several previous reports of group therapy with suicidal individuals (Alfaro, 1970; Farberow, 1968, 1972; Frederick & Farberow, 1970; Indin, 1966; Levine & Schild, 1969; Reiss, 1968).
- Means restriction via limiting rx's (mainly in Europe)

1965-Call for PH approach to suicide by Dublin
1968-Chicago Meeting. Shneidman proposed the following accomplishments in suicidology (see Fig 1)
Source: Shneidman, E.S. (1988), Some Reflections of a Founder. Suicide and Life-Threat Behavi, 18: 1–12.

1970: In 1966 there were three suicide prevention centers in this country; by 1970 there were over 200
Source: Shneidman, E.S. (1988), Some Reflections of a Founder. Suicide and Life-Threat Behavi, 18: 1–12.

1972: McGee, R. K., Richard, W. C. and Bercun, C. (1972), A Survey of Telephone Answering Services in Suicide Prevention and Crisis Intervention Agencies. Suicide and Life-Threat Behavi, 2: 42–47.

- Subsequent to the original innovation of the 24-hour telephone service (Farberow, Shneidman, Litman, Wold, Heilig, & Kramer, 1966; Litman, Farberow, Shneidman, Heilig, & Kramer, 1965), it (24 hour hotline) has become a standard component of suicide prevention services.

1972: Kiev, A. (1972), New Directions for Suicide Prevention Centers. Suicide and Life-Threat Behavi, 2: 189–193. doi: 10.1111/j.1943-278X.1972.tb00083.x

- Experience in clinical settings, as well as suicide prevention centers, generally has been restricted to patients seeking help, who are not necessarily representative of the larger group at risk in the general population. This has given us a limited perspective on the extent of the problem in the community. We need to train gatekeepers to develop greater skill in decoding the complaints people make in various settings so as to be able to judge the presence or absence of underlying psychopathological processes. In this regard, we have been actively working with the Academy of Pastoral Counselling to assist them in differentiating psychiatric from theological problems and in more effectively initiating the appropriate psychiatric referral when it is indicated without relinquishing their pastoral role.

1976- Restricting access to Lethal Means: UK-Coal gas story

1976: Motto, J. A. (1976), Suicide Prevention for High-Risk Persons Who Refuse Treatment. Suicide and Life-Threat Behavi, 6: 223–230. doi: 10.1111/j.1943-278X.1976.tb00880.x

- Postcard intervention developed for people who attempted suicide but refused follow-up

*This seems to be a turning point
1979: Motto, J. A. (1979), New Approaches to Crisis Intervention. Suicide and Life-Threat Behavi, 9: 173

- Innovative crisis intervention programs generally take either of two forms—a new target population or a new procedure. A few combine both.
    - Focusing on a *new target population* implies that specific center personnel have a special interest, experience and training or knowledgeability about a particular client group, and will focus their efforts on responding to that group's needs.

development of national standards for nursing home care, and creation of community volunteer programs for the unemployed and retired."

"The future reduction of suicidal behaviors will be dependent on a number of variables, not least of which will be political will and societal pressures to support large-scale, multidimensional, long-term efforts. Patience and persistence will be critical attributes for prevention programs and prevention professionals. Successful translation of theory and concepts into practical programs that are well received by target populations is critical (Kelly, Dassoff, Levin, Schreckengost, & Altman, 1988). Much will depend on the elegance and appropriate application of evaluation research and cost-effectiveness and coat-benefit analyses to the programs being administered. We are on the verge of clarifying concepts of risk reduction, risk factors, protective factors, cumulative effects of comorbidity, etiology and pathogenesis of maladaptive behaviors and sequences, and measurement of outcome variables over time (Mrazek & Haggerty, 1994). With such advances in the next few years, we will have available the necessary armamentarium to launch a full-scale attack on the incidence and prevalence of suicidal behaviors. We look forward to the year 2000."

Article by Canetto states: Traditional suicide prevention programs have focused on providing services to suicidal ideators (Canetto 1995). Also references a meta-analysis of suicide prevention centers that shows no effect... One limitation of these prevention programs is that they are set up to intervene with persons who are already suicidal. It could be argued that it is too late to prevent suicidal behavior when the person is already in crisis, and that prevention efforts would be more successful if they addressed the development of suicidal ideation prior to such crises (Canetto 1995).

She states limiting access to lethal means is needed.

Quote by Albee provided: no mass disease or disorder afflicting humankind has ever been eliminated by attempts at treating affected individuals" (p. 370). And, "focus on sociocultural factors may be the most effective way to prevent suicidal behavior since there is little evidence of the efficacy of individual psychotherapies."

Article by Potter, in the same volume talks about CDC's Youth Suicide Prevention Program Resource Guide" and 8 strategies (school gatekeeper training, community gatekeeper training, general suicide education, screening, peer support, crisis centers and hotlines, means restriction, and postvention. These are referred to in a *later article (Berman, 1995 below) as the first generation of suicide prevention strategies*. Potter goes on to state,

""First, suicide prevention programs should be linked as closely as possible with professional mental health resources in the community. Second, communities should not rely on only one prevention strategy. Certain strategies tend to predominate among prevention efforts, despite limited evidence of their effectiveness. Promising but underused strategies (e.g., means restriction) should be incorporated into current programs where possible. Third, although a large percentage of suicide prevention efforts are directed toward adolescents and teenagers in school, suicide rates are higher among other segments of the population. Suicide prevention efforts for young adults aged 20–24 years and other age groups with high suicide rates should be expanded. Fourth, it is important to incorporate evaluation into new and existing suicide prevention programs when practical. Evaluation should include measures of, or closely associated with, the incidence of suicidal behavior."

"Nationally, numerous organizations are implementing an array of promising suicide prevention interventions. However, there is a need to develop, implement, and evaluate new innovative suicide interventions. Individual interventions are the foundation of most suicide prevention programs, yet it is preferable for prevention programs to move toward multifaceted approaches that include numerous interventions and multiple segments of the community. Community organization and networking should be vital components to any suicide prevention effort. The CDC's *Recommendations for... Containment of Suicide Clusters* (Centers for Disease Control and Prevention 1988) emphasizes the need for communities to get organized before they find they are in the midst of a crisis. Such preparation and implementation may reduce the likelihood of suicide clusters and may reduce endemic suicide rates..."The public health approach to suicide prevention is being adopted by a variety of federal, state, and local agencies, and community-based organizations. While progress has been made, further development of a public health oriented suicide prevention with a public health orientation is essential. While suicide prevention efforts have progressed, the framework suggested by the public health perspective has not been fully implemented. Suicide prevention in the United States needs more planning, coordination, and resources. With these, the public health perspective can be used to reduce the emotional and economic costs imposed on society by suicide and suicidal behavior."

between these changes and any of the variables studied. Suggestions for future research on state-level initiatives are presented.

- Attention to the problem of youth suicide at the federal level was first evidenced in the passage of the Youth Suicide Prevention Act of 1985, which provided funds for the support of model suicide prevention programs in local school districts.
- Survey conducted and asked about: legislation since 1980, mandated or recommended suicide prevention for schools, state funds for suicide prevention, question about curricula, task force for youth suicide, state plan for adolescent suicide
    - Results: 19 states had legislation for youth suicide prevention, 4 states had legislation mandating or recommending school curricula (other states had curricula however); 3 states had funding for school suicide prevention, 24 states had a council of some sort for youth suicide, 7 states had state plans. 9 states had state initiated or supported screening of youth. About half had state-sponsored research projects related to adolescent suicide. 13 states had crisis response plans.
    - Over one-half of the states reported that they were actively involved in such school and community gatekeeper training.
    - Gaps: There were some obvious gaps in the preventive intervention strategies that were reported by the states. Very few states sponsored public education campaigns to restrict access to lethal means of suicide (handguns, drugs, and other common methods of suicide) in spite of the strong evidence; the lack of adequate funding to initiate, evaluate, implement, and disseminate successful programs and the lack of cohesive and coordinated state plans aimed at long-term change.
    - The results of the ANOVA indicated that while the changes in suicide rates over time were statistically significant, there was no relation between these changes and any of the variables studied
    - between 1979 and 1994 most states have initiated one or more measures intended to address the problem of adolescent suicide. However, with only a few exceptions, most state initiatives directed at preventing youth suicide occurred in the mid-1980s following, or in concert with, the passage of the Youth Suicide Prevention Act of 1985 (House Report No. 4650, 1986). Since then, many programs have been allowed to lapse and some legislation has been rescinded or allowed to expire
    - The finding of statistically significant changes in suicide rates over time but no relation between these changes and any of the variables studied is consistent with a similar study by Lester (1992), who examined the association between state activities addressing youth suicide and youth suicide rates from 1980 and 1987. He found that of the nine activities undertaken (legislation, government involvement, commission task force, manuals and brochures, school curriculum, training conferences, priority policy plan, direct services, and special studies) only three activities (legislation, commission task force, and manuals and brochures) showed any statistically significant association, with less of an increase in youth suicide rates.
- Second is a review of policies and efforts in 50 states

METHODOLOGY

Suicide prevention programs were identified by contacting suicide prevention experts in the United States and Canada and asking them to name and describe suicide prevention programs for adolescents and young adults that, based on their experience and assessment, were likely to be effective in preventing suicide. After compiling an initial list, program representatives were contacted and asked to describe the number of persons exposed to the intervention, the number of years the program had been operating, the nature and intensity of the intervention, and the availability of data to facilitate evaluation. Program representatives were also asked to identify other programs that they considered exemplary. Representatives from these programs were contacted and asked to describe their programs. The list of programs was further supplemented by contacting program representatives who participated in the 1990 national meeting of the American Association of Suicidology and by soliciting program contacts through *Newslink*, the association's newsletter.

Suicide prevention programs on the list were then categorized according to the nature of the prevention strategy using a framework of eight suicide prevention strategies:

- **School gatekeeper training**. This type of program is designed to help school staff (e.g., teachers, counselors, and coaches) identify and refer students at risk for suicide. These programs also teach staff how to respond to suicide or other crises in the school.
- **Community gatekeeper training**. These programs train community members (e.g., clergy, police, merchants, and recreation staff) and clinical health-care providers who see adolescent and young adult patients (e.g., physicians and nurses) to identify and refer persons in this age group who are at risk for suicide.
- **General suicide education.** Students learn about suicide, its warning signs, and how to seek help for themselves or others. These programs often incorporate a variety of activities that develop self-esteem and social competency.
- **Screening programs.** A questionnaire or other screening instrument is used to identify high-risk adolescents and young adults and provide further assessment and treatment. Repeated assessment can be used to measure changes in attitudes or behaviors over time, to test the effectiveness of a prevention strategy, and to detect potential suicidal behavior.
- **Peer support programs.** These programs, which can be conducted in or outside of school, are designed to foster peer relationships and competency in social skills among high-risk adolescents and young adults.
- **Crisis centers and hotlines.** Trained volunteers and paid staff provide telephone counseling and other services for suicidal persons. Such programs also may offer a "drop-in" crisis center and referral to mental health services.
- **Restriction of access to lethal means.** Activities are designed to restrict access to handguns, drugs, and other common means of suicide.
- **Intervention after a suicide.** These programs focus on friends and relatives of persons who have committed suicide. They are partially designed to help prevent or

potential effectiveness of programs that seek to identify and refer suicidal adolescents and young adults for mental health care.

- **Some potentially successful strategies are applied infrequently, yet other strategies are applied commonly.** Despite evidence that restricting access to lethal means of suicide (e.g., firearms and lethal dosages of drugs) can help to prevent suicide among adolescents and young adults, this strategy was not a major focus of any of the programs identified. Other promising strategies, such as peer support programs for those who have attempted suicide or others at high risk, are rarely incorporated into current programs.

  In contrast, school-based education on suicide is a common strategy. This approach is relatively simple to implement, and it is a cost-effective way to reach a large proportion of adolescents. However, evidence to indicate the effectiveness of school-based suicide education is sparse. Educational interventions often consist of a brief, one-time lecture on the warning signs of suicide—a method that is unlikely to have substantial or sustained impact and that may not reach high-risk students (e.g., those who have considered or attempted suicide). Further, students who have attempted suicide previously may react more negatively to such curricula than students who have not. The relative balance of the positive and the potentially negative effects of these general educational approaches is unclear.

- **Many programs with potential for reducing suicide among adolescents and young adults are not considered or evaluated as suicide prevention programs.** Programs designed to improve other psychosocial problem areas among adolescents and young adults (e.g., alcohol- and drug-abuse treatment programs or programs that provide help and services to runaways, pregnant teenagers, and/or high school dropouts) often address risk factors for suicide. However, such programs are rarely considered suicide prevention programs, and evaluations of such programs rarely consider their effect on suicidal behavior. A review of the suicide prevention programs discussed in the *Resource Guide* indicated that only a small number maintained working relationships with these other programs.

- **The effectiveness of suicide prevention programs has not been demonstrated.** *The lack of evaluation research is the single greatest obstacle to improving current efforts to prevent suicide among adolescents and young adults.* Without evidence to support the potential of a program for reducing suicidal behavior, recommending one approach over another for any given population is difficult.

RECOMMENDATIONS

Because current scientific information about the efficacy of suicide prevention strategies is insufficient, the *Resource Guide* does not recommend one strategy over another. However, the following general recommendations should be considered:

- **Ensure that suicide prevention programs are linked as closely as possible with professional mental health resources in the community.** Strategies designed to increase referrals of at-risk adolescents and young adults can be successful only to

the extent that trained counselors are available and mechanisms for linking at-risk persons with resources are operational.

- **Avoid reliance on one prevention strategy.** Most of the programs reviewed already incorporate several of the eight strategies described. However, as noted, certain strategies tend to predominate despite insufficient evidence of their effectiveness. Given the limited knowledge regarding the effectiveness of any one program, a multi-faceted approach to suicide prevention is recommended.
- **Incorporate promising, but underused, strategies into current programs where possible.** Restricting access to lethal means of committing suicide may be the most promising underused strategy. Parents should be taught to recognize the warning signs for suicide and encouraged to restrict their teenagers' access to lethal means. Peer support groups for adolescents and young adults who have exhibited suicidal behaviors or who have contemplated and/or attempted suicide also appear promising but should be implemented carefully. Establishment of working relationships with other prevention programs, such as alcohol- and drug-abuse treatment programs, may enhance suicide prevention efforts. Furthermore, when school-based education is used, program planners should consider broad curricula that address suicide prevention in conjunction with other adolescent health issues before considering curricula that address only suicide.
- **Expand suicide prevention efforts for young adults.** The suicide rate for persons in this age group is substantially higher than that for adolescents, yet programs targeted toward them are sparse. More prevention efforts should be targeted toward young adults at high risk for suicide.
- **Incorporate evaluation efforts into suicide prevention programs.** Planning, process, and outcome evaluation are important components of any public health effort. Efforts to conduct outcome evaluation are imperative given the lack of knowledge regarding the effectiveness of suicide prevention programs. Outcome evaluation should include measures such as incidence of suicidal behavior or measures closely associated with such incidence (e.g., measures of suicidal ideation, clinical depression, and alcohol abuse). Program directors should be aware that suicide prevention efforts, like most health interventions, may have unforeseen negative consequences. Evaluation measures should be designed to detect such consequences.

For a copy of the full report, *Youth Suicide Prevention Programs: A Resource Guide*, write to Lloyd Potter, Ph.D., M.P.H., at the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 4770 Buford Highway, Mailstop K-60, Atlanta, GA 30341-3724. Single copies are available free of charge.

Reference

1. CDC. Youth suicide prevention programs: a resource guide. Atlanta: US Department of Health and Human Services, Public Health Service, CDC, 1992.

ameliorate those precipitating conditions that are proximally or temporally related to the expression of the disease.

Injury Control Models

William Haddon, Jr. (1968, 1980) first expanded the public health model of pathogenesis to include an injury control approach. Haddon (1967, 1968, 1980) set forth 10 unintentional injury control strategies to break the chain of injury causation. These strategies fall into the tripartite concept of primary, secondary, and tertiary prevention, and deal, respectively, with the preinjury, injury, and postinjury phases (Institute of Medicine – IOM, 1985; Department of Health and Human Services – DHHS, 1991).

The advantage of injury control modeling is that it allows for the identification of multiple causes that, in and of themselves, may be necessary, but not sufficient, to propel the individual to complete a suicidal act. Thus, one does not necessarily have to strongly believe in or defend any one particular cause, or limit one's interventions to only that cause. The modeling allows for the displaying of multiple causes and for an objective development and identification of the most cost-effective intervention. Furthermore, it allows for the identification of various methods to identify and break the chain of disease causation at its weakest link. The weakest link might be proximal or distal to the disorder and might involve passive or active countermeasures.

Only recently have those in the mental health field revisited these approaches and attempted to apply them to suicide prevention (DHHS, 1991). Under this conceptualization, suicide becomes the direct result of an injury that was not prevented. The beauty of this approach is that one can stratify the various actions that can be taken to address each of the various components that together become sufficient for the suicidal act to occur.

Table 1 outlines Haddon's injury control strategies, with our own examples that relate to issues of suicide prevention. This approach provides an elegant means of identifying testable hypotheses and developing preventive interventions that are specifically linked to a particular strategy in a particular phase or at a particular level of prevention, and allows for a means of evaluating the outcome.

One major conceptual problem in adapting the Haddon injury control model to the study of suicide prevention is the underlying assumption in injury control strategies that the "injury" is *unintentional*. The concept is that injuries are "accidents" that are not intended to occur. However, the prevailing perspective in the field of suicide is that suicidal behaviors are *intentional* and under the direct control of the individual involved. There is some interesting theoretical and practical discussion of whether injury control models can be applied to suicide attempts and suicide completions (DHHS, 1991). For purposes of this discussion, however, we will assume that a certain percentage of suicidal behaviors are amenable to injury control approaches.

Much research on suicide and on nonfatal self-injury has emphasized personal characteristics and methods of treating suicidal individuals. Changes in the physical and social environment, and their effect on suicide rates have been the subject of little research to date. "The validity of the widespread assumption that non-fatal suicide attempts represent a lack of desire to kill oneself and, therefore, involve the choice of less lethal means, should be subjected to scientific scrutiny; there is evidence that reducing the availability of popular means of committing suicide can cause a major reduction in the suicide rate" (IOM, 1985, p. 45).

One example of this approach might be the reduction of suicides by domestic gas inhalation (Lester & Abe, 1989). The causes for death were secondary to the chemical content of the gas that was used for domestic use (stoves in the kitchen). The gas was easily and readily available and accessible. Furthermore, the gas was

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From: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC)
Sent: 20 Feb 2017 17:15:33 -0500
To: Mercy, James (CDC/ONDIEH/NCIPC);Young, Joni (CDC/ONDIEH/NCIPC);Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Herbst, Jeffrey (CDC/ONDIEH/NCIPC);Payne, Gayle H. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Massetti, Greta M. (CDC/ONDIEH/NCCDPHP)
Cc: Dorigo, Leslie (CDC/ONDIEH/NCIPC);Lenard, Courtney (CDC/ONDIEH/NCIPC)
Subject: Weekly DVP Media Report

Media Coverage

BULLYING

Feb. 10, 2017 **"New Mexico Lawmaker Aims to Curb Bullying Through Counseling"**

- **Publication:** KRQE - Fox Affiliate: Santa Fe, N.M.(UVM: 1.2M*)
- "New Mexico already has a law on the books for school bullies. But one lawmaker wants to take it a step further and get the parents of bullies involved. The lawmaker doesn't think enough is being done to stop the bullying. Rep. Elizabeth Thomson says CDC statistics suggest at least 50,000 New Mexico kids don't feel safe reporting bullying at school."

GUN VIOLENCE

Feb. 12, 2017 **"Boston Is a Shooters' Paradise"**

- **Publication:** *Boston*(UVM: 1.3M*)
- "During a six-month investigation, Boston obtained police records through a public information request and examined 618 shootings over 994 days, from the start of 2014 through September 20, 2016. The results were staggering: During that time frame, Boston police had arrested fewer than 4 percent of gunmen involved in non-fatal shootings. That means, for instance, that detectives have not arrested anyone for shooting 14-year-old Keira Harrison three times as she watched Fourth of July fireworks on Bower Street this past summer. And police have not captured whoever shot a 15-year-old in South Boston in August, or the person who shot a seven-year-old on Bowdoin Street. In fact, the data revealed that police had not made a single arrest in any of the 19 non-fatal shootings of Boston minors under age 17. (And that was before the October shootings of two-year-old and nine-year-old girls in separate incidents.)"

"The Republican War on Facts"

- **Publication:** *Who. What. Why.* (UVM: 240.8K*)
- "While Republicans love to refer to themselves as the 'Party of Lincoln,' they seem to disagree wholeheartedly with the sentiment of this quote. They certainly don't want the American people to have facts — and nobody in their right mind would ever refer to their current standard-bearer as 'Honest Don.' One of the best-known examples is the so-called Dickey Amendment, which was first passed in 1996 and effectively ended the Centers for Disease Control and Prevention's research on gun violence. Rep. Jay Dickey (R-AR), after whom the amendment is named, has since expressed regret that the language he

introduced has had that effect on this type of research."

Feb. 13, 2017 **"CNN Scoop: Bullet Fragments in Body Can Cause Lead Poisoning, High Blood Pressure"**

- **Publication:** *Breitbart* (UVM: 108.0M*)
- "They point to a study by the Centers for Disease Control and Prevention which was published February 10 and report, 'Fewer than 1% of cases of adults with elevated blood lead levels were caused by retained bullet fragments.' Yet CNN stresses that five percent of the 'fewer than 1%...could be linked to bullets.'"

Feb. 14, 2017 **"Our Opinion: State Physicians Have Role in Gun Safety"**

- **Publication:** *The Berkshire Eagle* (UVM: 381.9K*)
- "Massachusetts had the lowest gun death rate in the country in 2015 and for good reason. A new initiative announced Monday by state Attorney General Maura Healey should further reduce gun-related injuries and deaths. 'Gun violence is a major public health threat and physicians can play a key role in curbing the violence' said Massachusetts Medical Society (MMS) President Dr. James Gessner Monday. In Washington, Congress has blocked federal research into the public health threat posed by guns since 1996. When President Obama issued an executive order in 2012 in the wake of the Newtown school massacre instructing the Centers for Disease Control to explore the reasons for gun violence and ways to prevent it, Congress turned back bills giving the CDC $10 million to fund that effort. According to Everytown for Gun Safety Research, 13,280 people were killed and 26,800 people were injured by guns in 2015 in the U.S. (these figures exclude suicides), so guns are plainly a threat to public health and should be treated as such in Massachusetts, even if Washington refuses to for reasons of ideology."

"This MIT Freshman is Developing a Smart Gun to Save Lives – How?"

- **Publication:** *Nature World News* (UVM: 401.1K*)
- "Kai Kloepfer has been developing his prototypes since high school. His primary asset is that there is a fingerprint-recognition software in the middle of the handle. This means owners will be the only one allowed to use their guns and cannot be used by others. Kloepfer told CBS News in an interview that this means unauthorized people like children or teenagers looking to harm themselves will be unable to access firearms that are owned by other people such as their parents. This is particulary relevant as a recent study in the journal Pediatrics reveals that about 20 children and teenagers are shot in the U.S. every day. According to the New York Times, data from the Centers for Disease Control and Prevention (CDC) and the FBI showed that there are more children killed by guns per year (80) than police officers (50)."

Feb. 15, 2017 **"If You've Been Shot, It May Be Prudent to Have the Bullet Removed"**

- **Publication:** *The Atlantic* (UVM: 46.9M*)
- "When a bullet penetrates a person's body, sometimes it follows a clean path and lands in a harmless place. First-time gunshot victims tend to be surprised to learn that the bullet often doesn't need to be removed. Assuming that bullet fragments aren't lodged near something like a

major vessel or plexus, the standard practice among surgeons has been to let things be. Even Curtis '50 Cent' Jackson, who had speech-altering shrapnel lodged in his tongue, was advised by his doctors to leave it in, he said in 2013, because 'it might do more damage to my nerves and taste buds.' The challenges to understanding the problem are many, starting with the fact that NRA lobbyists have rendered the CDC effectively forbidden from studying gun violence."

Feb. 16, 2017 **"Congress Shows its Hypocrisy on Gun Control"**

- **Publication:** *The Washington Post*(UVM: 272.6M*)
- "Every time there is a gun-violence tragedy in our country, we hear these same arguments from politicians who consistently oppose common-sense gun-safety legislation aimed at keeping firearms out of dangerous hands... the National Rifle Association is currently pushing radical legislation to make it easier for people to buy firearm silencers, which could place these devices into dangerous hands and make it harder for bystanders and law enforcement to hear, locate and react quickly to gunshots. The NRA claims this is about public health — but after it spent decades opposing funding for Centers for Disease Control and Prevention research into how gun violence kills so many Americans, who buys that?"

SEXUAL VIOLENCE

Feb. 10, 2017 **"Fifty Shades Darker Isn't Empowering, It's Abuse"**

- **Publication:** *The Huffington Post* - UK(UVM: 15.4M*)
- "It's finally upon us - the long-awaited release of Fifty Shades Darker, the second installment in the Fifty Shades of Grey film trilogy. But rather than swooning, I find myself shuddering. An analysis of the first book found that the so-called romantic relationship between Christian and Ana was characterised by intimate partner violence. Using the US Centers for Disease Control and Prevention's definitions, researchers found that emotional abuse and sexual violence were pervasive throughout, noting that emotional abuse was present 'in nearly every interaction.' This was evidenced in stalking, such as tracking Ana's movements via phone and computer technology, limiting Ana's social involvement, intimidation and threats."

"What Parents Need to Know About Teen Dating Violence"

- **Publication:** *She Knows* (UVM: 13.0M*)
- "One in 3 teens in the U.S. will experience physical, sexual or emotional abuse by someone they're in a relationship with and 1.5 million teenagers report being in an abusive relationship each year. And 43 percent of dating college women report experiencing abusive dating behaviors."

Feb. 13, 2017 **"The Daily Northwestern - Northwestern University Student Newspaper"**

- **Publication:** *The Daily Northwestern* (UVM: 177.4K*)
- "U.S. Sen. Tammy Duckworth (D-Ill.) and Sen. Dick Durbin (D-Ill.) announced Thursday that over $1 million dollars in federal funding has been allocated to the Illinois Department of Public Health to support sexual assault prevention efforts. Prevention and Education Program.

According to information on the CDC website, the program was created with the passage of the Violence Against Women Act in 1994. The program 'seeks to develop and strengthen sexual violence prevention efforts at the local, state, and national level."

"Hundreds Walk to Rise Against Domestic Violence"

- **Publication:** *Midland Daily News* (UVM: 329.0K*)
- "The walk was part of the One Billion Rising movement, which is a global movement to end violence against women. One in three women will be a victim of violence over the course of her lifetime. With a world population of seven billion men and women, that equates to one billion women and girls who are victims. 'I rise because I see so many people who domestic violence has affected.' Wakeman said. 'Whether people know it, they know somebody who is a survivor. If domestic violence was anything but common, then the CDC (Centers for Disease Control and Prevention) would classify it as an epidemic, but it happens behind closed doors. We don't want it to be a conversation stopper anymore, many people shut down when it's mentioned. We need to have these conversations because the only way that we are going to fully eradicate and wipe out domestic violence is to talk about it. We need to talk about these issues in our community.'"

"Teen Dating Forum to be Held by Centers for Disease Control this Week"

- **Publication:** *Craig Daily Press* (UVM: 167.1K*)
- "Love shouldn't hurt and this month the Centers for Disease Control and Prevention are offering tools to prevent teen dating violence. 'Youth violence affects all communities and all members of a community. It is a leading cause of death for adolescents and young adults,' according to VetoViolence.cdc.gov. VetoViolence is the CDC's online violence prevention portal."

"Readers Write: Letters to the Editor, February 13, 2017"

- **Publication:** *Alaska Daily News* (UVM: 2.6M*)
- "Polarized politics have reached a new level in D.C., but fortunately some Alaska politicians seem to still be interested in standing for all of their constituents and looking to the facts. Republican Sen. Lisa Murkowski is one of these politicians who deserves to be thanked, specifically for speaking in support of Planned Parenthood, which offers sexually transmitted infection (STI) screening and prevention to Alaskans."

"Ordering this Shot Could Help Save Your Life "

- **Publication:** WISN - ABC Affiliate: Milwaukee, Wis. (UVM: 1.0M*)
- "The 'Angel shot' is a secret code alerting a bartender that help is needed. Bars across the country are offering the "Angel Shot." It's not on the menu and it's not really a drink. Order the shot and the bartender, at participating bars, will know you need help. Bar-goers now have a safe way out of an uncomfortable situation at their favorite establishment. Data from the Centers for Disease Control and Prevention CDC shows that nationwide, 51.1 percent of female victims reported being raped by an intimate partner and 40.8 percent by an acquaintance."

"The Most Dangerous States For Online Dating"

- **Publication:** *Forbes* (UVM: 131.2M*)
- "Who's on Tinder, Match, Plenty of Fish, and other online dating apps and sites? Well, maybe someone who likes long walks on the beach. But also maybe someone who likes your wallet or even your identity. You could find someone with a good sense of humor or good eyes. Or perhaps greenish yellow discharge and burning on urination. Yes, dating online is not always safe, and according to pieces by Backgroundchecks.org, highspeedinternet.com, and Safewise, some states may be more dangerous than others."

Feb. 15, 2017 **"Nathan Miller: Teen Dating Violence Affects 1.5 Million Annually"**

- **Publication:** *Lebanon Democrat* (UVM: 99.2K*)
- "February is traditionally the month best associated with the color red, the emotional feeling of love and the complexities of the human heart. However, February is also the month that teens and parents of teens are reminded that teen dating violence is a very real issue in the U.S. and here in Wilson County."

"Take a Stand Against Teen Dating Violence"

- **Publication:** *The Hays Daily News* (UVM: 106.7K*)
- "February is Teen Dating Violence Awareness Month. Ironically, it also is the month we celebrate Valentine's Day with our significant others. Sadly, some of those relationships are unhealthy, and possibly even dangerous...The U.S. Centers for Disease Control and Prevention report one in four teens report being hit, slapped, stalked, sexually assaulted or emotionally abused by a dating partner. Approximately one in five women and nearly one in seven men who ever experienced rape, physical violence or stalking by an intimate partner first experienced the abuse between the ages of 11 and 17."

Feb. 16, 2017 **"Study: Idaho a Safe Place to Date Online, Washington Less So"**

- **Publication:** *The Spokesman-Review* (UVM: 1.5M*)
- "Online dating applications often are a staple of single people's phones. Apps like Tinder, Bumble, OkCupid, Match.com, Grindr, or Christian Mingle, host millions of users all looking to meet that special someone. In a report published by the company and co-sponsored by Highspeedinternet.com, states were ranked on how safe they were to date online by comparing cybercrime data from the U.S. Department of Justice, crime statistics from the FBI's Uniform Crime Report and sexually transmitted disease rates compiled by the Centers for Disease Control and Prevention."

"Yater: Dating violence serious issue for teens"

- **Publication:** *Daily News Journal* (UVM: 194.3K*)
- "February is traditionally the month best associated with the color red, the emotional feeling of love and the complexities of the human heart. However, February is also the month that teens and parents of teens are reminded that teen dating violence is a very real issue in the U.S. and here in Rutherford County. The Centers for Disease Control note that unhealthy relationships can start early and last a lifetime. Teens often think some behaviors, like teasing and name calling, are a

"normal" part of a relationship. However, these behaviors, according to the CDC, can become abusive and develop into more serious forms of violence."

SUICIDE

Feb. 10, 2017 **"Six Reasons Why Individuals Choose Suicide"**

- **Publication:** *Psychology Today* (UVM: 24.2M*)
- "Although we are just beginning to say hello to February, this year has been off to a sad start with several people in my immediate circle—individuals I knew personally, or who are connected to friends or family members—committing suicide. There's no easy way to acknowledge or accept this, or even an uncomplicated way to type those words. Each has had a different reason for doing so, but what remains constant is the sadness left in the wake."

Feb. 12, 2017 **"Does a Child Need an Intervention? Learn the Signs"**

- **Publication:** *Lowell Sun* (UVM: 462.0K*)
- "The school district will teach residents to be "first-aiders" able to assess whether a child needs help with mental-health issues or substance abuse… According to the Centers for Disease Control and Prevention, in 2010 suicide was the second highest cause of death among those ages 12 through 17. The CDC reported that suicide can be the result of mental disorders."

Feb. 13, 2017 **"Elsevier Announces First Large-Scale Analysis of Suicide Motivation Across Multiple Ages in the Same Time Period"**

- **Publication:** Benzinga.com (UVM: 1.4M*)
- **"**Elsevier, a world-leading provider of scientific, technical and medical information products and services, today announced the publication of Explaining Suicide: Patterns, Motivations, and What Notes Reveal by Cheryl Meyer, Taronish Irani, Katherine Hermes and Betty Yung. It is the first large-scale analysis of suicide motivation across multiple ages in the same time period, made possible via a unique dataset of all suicide notes collected by the coroner's office in southwestern Ohio from 2000 through 2009. At the same time, Elsevier announced publication of four additional psychology books."

"Anti-Suicide Drugs Market - Trends, Outlook, and Opportunity Analysis, 2016-2024"

- **Publication:** *Open PR* (UVM: 275.1K*)
- **"**Suicide is viewed as an end stage of depression, whereas it is a distinct medical condition that needs special attention. The current market for the treatment of suicide is a subset of the drugs used to treat anxiety and depression… According to the Centers for Disease Control and Prevention (CDC) estimate, more than 9 million people in the United States reported having suicidal thoughts in 2013. The suicide rates in the country have been increasing according to the American Foundation for Suicide Prevention, reaching a suicide rate of 12.93 per 1,000 populations in 2014."

"Mental Health Programs for Employees are Becoming Commonplace in the Industrial Workplace"

- **Publication:** *Greater Baton Rouge Business Report* (UVM: 202.7K*)
- "For an industrial contractor like Turner Industries, safety is paramount. But ensuring safety takes more than sound equipment and well-trained workers. People with mental health issues like depression or substance abuse can lose their focus on the job site, putting themselves and their co-workers in jeopardy, says Dan Burke, Turner's director of corporate benefits. So in January of 2014 the company put in place an employee assistance program to help its workers address potential issues before those issues get out of hand. Such programs are becoming more commonplace, providers say, although many employees aren't taking full advantage of them."

Feb. 14, 2017 **"Pittsylvania County Group Working to Get Suicide Prevention Program in School System"**

- **Publication:** WSET - ABC Affiliate: Lynchburg, Va. (UVM: 731.9K*)
- "A group on the southside is making a concerted effort to prevent teen suicide. They're talking to Pittsylvania County supervisors about a program they'd like to work into the school system. The CDC reports a nationwide survey found 16% of students reported seriously considering suicide."

"Student Suicide: Moving Beyond Blame to Understanding"

- **Publication:** *Education Week* (UVM: 1.6M*)
- "Suicide is the worst of losses, especially when the victim is an adolescent. It's every parent's nightmare. And it's every principal's, too—not only for the horrific loss of the student, but for the censure that can often follow. Parents, community members, and even students may criticize the school for too much stress and pressure, too much homework and competition, and too little support. As the superintendent of schools in Palo Alto, Calif.—a district with a teen-suicide rate four times the national average—noted last fall, 'any school that experiences a student suicide should brace for a tsunami of blame.'"

* Total unique visits per month of publication's website (within one month prior to date reported)

From: ICEHS_Section@connect.apha.org on behalf of Dr. Ted R. Miller
Sent: 17 Jun 2016 13:45:10 +0000
To: ICEHS Section
Subject: [ICEHS Section] Re: article on guns & suicide

The provided article from Dr. Olson was
Centerwall BS. (1991). Homicide and the prevalence of handguns: Canada and the United States, 1976 to 1986. American Journal of Epidemiology, 134(11): 1245-1260

The article does not address suicide at all, only homicide. And the statement that Dr. Olsen quoted does not appear in it but rather in a book by gun-rights advocate Gary Kleck, who reports the statement came from a letter to him.

For a meta-analysis of 16 studies that do address suicide, see:
Anglemyer A, Horvath T, Rutherford G. (2014). The Accessibility of Firearms and Risk for Suicide and Homicide Victimization Among Household Members: A Systematic Review and Meta-analysis. Annals of Internal Medicine, 160(2):101-110. open access at
http://annals.org/article.aspx?articleid=1814426

The meta-analysis concludes that the risk of a suicide in the home is 3.24 times as high in homes with guns relative to homes with no guns. Yesterday I spoke at Columbia University's excellent conference Innovations in Translating Injury Research into Effective Prevention. David Hemenway gave a keynote address on suicide prevention.

David says that the elevated odds do not imply we should ban guns. Rather it implies that we need to educate gun owners that if a friend is going through a stressful transition like divorce, job loss, or a serious illness or death in the family, it often is wise to babysit their guns. Suicide is very impulsive, and it is best if only less lethal means are at hand if the impulse strikes. Utah gun owners now are including suicide prevention training in their gun safety training. David's team at Harvard has been working with gun shop owners to help them teach their clerks how to recognize when someone is trying to buy a gun to kill themselves (don't care about brand, just want one or two bullets).

Ted Miller
Pacific Institute for Research and Evaluation
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Phone (301) 593-7471
Cell: (240) 441-2890

From: ICEHS_Section@connect.apha.org on behalf of Dr. Donald Wayne Olson
Sent: Thursday, June 16, 2016 9:27 PM
To: Leslie Fisher; ICEHS Section
Subject: [ICEHS Section] Re: fyi article on guns and cdc

Greetings Les

I've attached an article that expressly studied the question: WOULD BANNING FIREARMS REDUCE MURDER AND SUICIDE?

From: Carr, Colleen
Sent: 4 Nov 2016 02:21:15 +0000
To: Belyeu, Avery;'Jane Pearson';'Dan Reidenberg';'John Draper';Stout, Elly;'Jack Benson';'Stephanie Coggin';eneely@reingold.com;Stone, Deborah (CDC/ONDIEH/NCIPC);'Amy Kulp';'Frances Gonzalez';'Michael Rosen';'Ashley Vactor';Pearson, Jane L (NIH/NIMH) [E];Holland, Kristin (CDC/ONDIEH/NCIPC);Melnyk, Liliya;Crosby, Alexander (CDC/ONDIEH/NCIPC);Hedegaard, Holly (CDC/OPHSS/NCHS);'Paul Lauricella';Sobottka, Linda;Gass, Jesse;Scanlon, Michaelle (NIH/NIMH) [C];Reed, Jerry;Padgett, Jason;Warner, Margaret (CDC/OPHSS/NCHS)
Cc: Zeller, Eileen (SAMHSA/CMHS);Alexis O'Brien;Kurikeshu, Rebecca (NIH/NIMH) [C];Steve Mendelsohn
Subject: Action Alliance Statement in response to 4 Nov. MMWR release

All,
The MMWR QuickStat is live on CDC's website if you would like to see it. We are putting the finishing touches on the Action Alliance statement and I will send that out to the full group by 9am tomorrow so folks can distribute via their communication channels.
Feel free to contact me with any questions.
Colleen
-----Original Appointment-----
From: Belyeu, Avery
Sent: Monday, October 31, 2016 3:50 PM
To: Belyeu, Avery; 'Jane Pearson'; 'Dan Reidenberg'; 'John Draper'; Stout, Elly; 'Jack Benson'; 'Stephanie Coggin'; eneely@reingold.com; 'Deborah Stone'; Carr, Colleen; 'Amy Kulp'; 'Frances Gonzalez'; 'Michael Rosen'; 'Ashley Vactor'; 'Pearson, Jane L (NIH/NIMH) [E]'; 'Holland, Kristin (CDC/ONDIEH/NCIPC)'; Melnyk, Liliya; 'Crosby, Alexander (CDC/ONDIEH/NCIPC)'; 'Hedegaard, Holly (CDC/OPHSS/NCHS)'; 'Paul Lauricella'; Sobottka, Linda; Gass, Jesse; 'Scanlon, Michaelle (NIH/NIMH) [C]'; Reed, Jerry; Padgett, Jason; Warner, Margaret (CDC/OPHSS/NCHS)
Cc: Zeller, Eileen (SAMHSA/CMHS); Alexis O'Brien; Kurikeshu, Rebecca (NIH/NIMH) [C]; Steve Mendelsohn
Subject: Action Alliance Media Messaging Work Group Call- Potential Data Release Planning Call.
When: Wednesday, November 02, 2016 3:00 PM-4:00 PM (UTC-06:00) Central Time (US & Canada).
Where: (b)(6) No passcode needed
Dear Media Messaging Workgroup,
Please join a call on Wednesday, November 2nd at 4pm ET/3pm CT/2pm MT/ 1pm PT to discuss an upcoming CDC Quickstat data release.
<< File: Agenda. Media Messaging Workgroup Call. 11.2.16.pdf >>
As in previous calls we will use this time to discuss the information we currently have about the data release and outline next steps for a coordinated and collaborative response.
Please access the call by calling (b)(6) (No passcode needed).
My Best,
Avery

From: Belyeu, Avery
Sent: 14 Mar 2017 21:36:10 +0000
To: Caraballo, Rachel;Mercy, James (CDC/ONDIEH/NCIPC);Robert Gebbia;Reed, Jerry;Magdala Labre;Stone, Deborah (CDC/ONDIEH/NCIPC);CMoutier@afsp.org;Stout, Elly;Bird, Doreen;heidi@heidibryan.com;edemello@naminh.org;jarrod.hindman@state.co.us;mruhe@naccho.org;Annmarie_white@urmc.rochester.edu;Zeller, Eileen (SAMHSA/CMHS);Dr. John Harrison;Heather.Stokes@livingworks.net;gigi@gcolombini.com;Carr, Colleen;Ken Norton;bprice@cadca.org;Melissa Helm;Torguson, Kimberly
Subject: Action Alliance Update: Transforming Communities Paper

Dear Working Group,
Thank you all for your feedback to the most recent version of the Transforming Communities paper. Your contributions were all very helpful and will result in an even stronger product.

Please note that the meeting this Friday, March 17th will be cancelled. In lieu of a meeting we would like to provide you with a few key updates:

- The paper is currently being finalized which includes copy editing and graphic design work. We are on track for a late March release.
- Communication leads from SPRC, the Action Alliance, AFSP, SAMHSA and CDC are working together to align our messages regarding this paper and the CDC Technical Package. As part of this process the Action Alliance is creating a communications guide that may be used by partner organizations when the Transforming Communities paper is released. We will share that with you prior to the release date so that you can participate in this unified message.
- We will convene a full group meeting in late April or early May to discuss how to maximize our collective impact on this topic.

Thank you for your ongoing collaboration. If you have any questions regarding the updates listed above please don't hesitate to reach out.
My Best,
Avery

Avery Belyeu
National Partnerships Associate
National Action Alliance for Suicide Prevention
The Education Development Center (EDC)
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
(828) 406-4029 (Direct)



From: Belyeu, Avery
Sent: 15 Dec 2016 15:26:53 +0000
To: Caraballo, Rachel;Carr, Colleen;Mercy, James (CDC/ONDIEH/NCIPC);Reed, Jerry;Robert Gebbia;Magdala Labre;Stone, Deborah (CDC/ONDIEH/NCIPC);CMoutier@afsp.org;Stout, Elly;Melissa Helm
Subject: Action Alliance: CBSP Meeting Agenda
Attachments: CBSP Call Agenda 12.16.16.docx

Hello All,
I look forward to speaking with you all tomorrow at 2pm ET/1pm CT/ 12pm MT/ 11am PT as part of the All-Group Call.
Attached to this email is the proposed agenda for that call along with a list of the potential reviewers that have been submitted up to this point.
Per our conversations last week the bulk of this call will be used to invite participants to share thoughts about the review process, identify gaps in our current list, and discuss a coordinated communications plan for the release of the White Paper and the CDC Technical Package.
If you have any thoughts about this agenda please don't hesitate to reach out. I will send this out to the entire group later today.
Thank you for your ongoing commitment to this important work.
My Best,
Avery

Avery Belyeu
National Partnerships Associate
National Action Alliance for Suicide Prevention
The Education Development Center (EDC)
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
(828) 406-4029 (Direct)



Community-based Suicide Prevention Priority

Meeting Agenda

Friday, December 16th

2pm Eastern/1pm Central/Noon Mountain/11am Pacific

- **Review of the project timeline:** (10 min) -*Bob Gebbia*
    - December 23rd
        - All feedback gathered from this group and integrated into the Draft White Paper
        - Survey created for external reviewers
    - January 2nd
        - Survey sent to external reviewers to solicit feedback
    - January 20th
        - Feedback gathered from external reviewers and integrated into draft white paper
    - January 27th
        - Summary of feedback from external reviewers compiled and provided to the working group
    - Late February- March
        - Draft is finalized and White Paper is released
- **External Review Process:** (20 min)-*Bob Gebbia*

  A small list of potential reviewers have been submitted.
    - Are there others we should add?
    - Are there any gaps in the expertise we are drawing on?
- **Coordinated Communications Plan:** (20 min)-*Jim Mercy*

  To maximize the impact of the release of the White Paper and the CDC Technical Package there should be a coordinated communications plan.
    - What are the next steps to draft a coordinated communications plan?

- **Next Steps**- (5 min) *Avery*

From: Padgett, Jason
Sent: 20 Jul 2016 18:19:17 +0000
To: Mercy, James (CDC/ONDIEH/NCIPC);Robert Gebbia;Reed, Jerry; (b)(6) Deborah (CDC/ONDIEH/NCIPC);cmoutier@afsp.org;Stout, Elly;Melnyk, Liliya
Subject: Co-lead prep info for Friday's call: Action Alliance: Community-based Suicide Prevention Priority Group Meeting (2pm Eastern/1pm Central/11am Pacific)
Attachments: Leader-staff-version-CBSP-Agenda-FullGroup-2016-07-22.doc, Final-Assignments.xlsx, Leadership Meeting Notes 070816 final.docx

Good afternoon all,
Attached you will find three items:

1. Agenda for Friday's full priority group call with comments/guidance for each of you
2. Assignments document to please familiarize yourselves with (especially Bob since you'll lead review/discussion of it on the call).
3. Notes from the 7/8 leadership call

The two key goals for Friday's call are to:

1. Better understand the CDC Technical package and how it impacts this work (how is complementary/aligned; how is it duplicative)
2. Ensure members understand their assignments and reach a decision about how to gather in smaller groups to identify core elements/key lessons from the programs/frameworks/approaches.

I'll share these, as well as re-attach the message from the last call re: notes/follow-up, with the full group a bit later this afternoon via Outlook and email so all have the meeting details.
If any of you have questions about the sections you will be facilitating, please let me know.
Kindly,
-Jason

Jason H. Padgett, MPA, MSM
Deputy Secretary, National Action Alliance for Suicide Prevention
Manager of National Partner Initiatives, Suicide Prevention Resource Center
Associate Project Director, EDC, Inc.
jpadgett@edc.org | Phone: 202-599-0532 | Skype: jason-sprc

***Envisioning A Nation Free From the Tragic Experience of Suicide ***

-----Original Appointment-----
From: Padgett, Jason
Sent: Monday, April 18, 2016 11:51 AM
To: Padgett, Jason; Mercy, James (CDC/ONDIEH/NCIPC; Robert Gebbia; Reed, Jerry; (b)(6) Deborah Stone; cmoutier@afsp.org; Stout, Elly; Chervin, Doryn; Melnyk, Liliya; Bird, Doreen; heidi@heidibryan.com; edemello@naminh.org; jarrod.hindman@state.co.us; mruhe@naccho.org; Annmarie_white@urmc.rochester.edu; Eileen.Zeller@samhsa.hhs.gov; Dr. John Harrison; Heather.Stokes@livingworks.net; gigi@gcolombini.com
Subject: Action Alliance: Community-based Suicide Prevention Priority Group Meeting (2pm Eastern/1pm Central/11am Pacific)

When: Friday, July 22, 2016 1:00 PM-2:00 PM (UTC-06:00) Central Time (US & Canada).
Where: TBD

TRANSFORMING COMMUNITIES:
COMMUNITY-BASED SUICIDE PREVENTION PRIORITY
PRIORITY GROUP MEETING
AGENDA
LEADER/STAFF VERSION-PLEASE REVIEW COMMENTS
JULY 22, 2016
2PM EASTERN/11AM PACIFIC

Welcome/Roll Call:	Jason H. Padgett	<5 minutes
CDC Technical Package presentation:	Deb Stone	<15 minutes

Resource: N/A

Key questions/discussion points:

- Do members have any specific questions about the presentation?

Discussion:	Jim Mercy	<15 minutes

Key questions/discussion points:

- How does the intended content of this technical package impact our white paper?

Assignments:	Bob Gebbia	<10 minutes

Resource: "Final Assignments.xlsx"

Key questions/discussion points:

- Review Assignments document
- Determine best way to have small group discussions (separate from August call or instead of August full group call)
- Present combined group results at September group call

Bonus Question:	Jerry Reed	<10 minutes

Key questions/discussion points:

- Fundable activities – specifically for community-based suicide prevention

Action Item Review & Next Steps	Jason	<5 minutes

- Action Items
- Next meeting: August 26, 2016 at 2pm Eastern/11am Pacific

Comment [PJ]: Co-leads/Proxies:
- Bob Gebbia, with Christine Moutier as proxy
- Jim Mercy, with Deb Stone as proxy
- Jerry Reed, with Elly Stout (unable to attend) as proxy

Members:
- Doreen Bird
- Heidi Bryan
- Gigi Colombini (unable to attend)
- John Harrison
- Elaine de Mello
- Jarrod Hindman (unable to attend)
- Heather Stokes
- Melanie Ruhe
- Ann Marie White
- Eileen Zeller

Staff:
- Maggie Labre
- Liliya Melnyk

Comment [PJ]: Jim/Deb – the goal here is for the two of you to take no more than 30 minutes for presentation and discussion. I'd like Jim as co-lead to lead discussion about how this might impact this group's efforts.

Comment [PJ]: Bob, I believe the related document is self-explanatory. But I am happy to step in and clarify. They key point here is to ensure folks know what group they are in, what is expected, and decide whether or not to use the August group call for purpose of groups meeting together (we can support that via 3 separate Webex OR conference calls).

Comment [PJ]: Jerry, you've got this … if below helps … key is to have folks send me ideas.

If you received a call today offering $1 million (or $5M or $10M or $50M) for, what would you propose? As you review the assignments given, and consider efforts across the country, please document these ideas and send them to Jason. Our goal is to keep

Program/Model/Framework/Approach	Person(s)	Date	
Broad Background items			
CDC Technical Package	Jim/Deb	22-Jul	
SPRC Effective Suicide Prevention	Linda	26-Jun	
Evidence-based Programs			G1
US Air Force Model	Bob/Christine		G1
Help for Life Campaign	Bob/Christine		G1
Model Adolescent Suicide Prevention Program	Doreen B.		G1
European Alliance Against Depression & OSPI-Europe	Doreen B.		G1
Other Suicide Prevention Programs			G1
Garrett Lee Smith Program	Eileen		G1
SAMHSA NREPP Programs	We are not diving into these as they are not broad community based approaches.		G1
Other Guidance/Models for Community-Based Prevention			
Suicide Prevention Focused			G2
Colorado	Jarrod		G2
Communities Matter Toolkit (Australia)	Elaine		G2
Connect	Elaine		G2
IIMHL	Jerry/Elly		G2
Living Works Suicide Safer Communities	Heather		G2
New South Wales Framework	Jarrod		G2
NICE (UK)	Heather		G2
Texas Suicide Prevention Toolkit (and/or any other state toolkits)	Heidi		G2
Non-SP Focused			
Channeling Change: Making Collective Impact Work	Elly (per her request)		G2
Coalition Primers & Toolkits (CADCA)	John		G3
Communities that Care (Univ. Washington)	Gigi		G3
Community Health Improvement Navigator	Jim/Deb		G3
Community Tool Box (Univ. Kansas)	Gigi		G3
County Health Rankings and Roadmaps Action Cycle (RWJ Foundation)	Melanie		G3
Getting to Outcomes	Ann Marie		G3
Strategic Prevention Framework	John		G3

Lead - Bob/Christine	2	G1
Doreen	2	G1
Eileen	1	G1
Lead-Jerry/Elly	2	G2
Elaine	2	G2
Heather	2	G2
Heidi	1	G2
Jarrod	1	G2
Lead-Jim/Deb	1	G3
Ann Marie	1	G3
Gigi	2	G3
John	2	G3
Melanie	2	G3

Directions

1. Locate your name on the chart. Note the assigned program(s), as well as your corresponding group number (G1, G2, or G3).
2. Search for information on your program(s) with the specific eye toward listing key elements/components of the program(s).
3. Each group has one of the three co-leads and their proxy assigned. We will work with them to identify a time for each group to gather before September 16th to discuss the key components of the full set of programs each group has been assigned. (We can help setup a Doodle poll to help with scheduling needs; or provide a conference line for your conversations).
4. During the group meeting, identify the core elements of the your program(s).
5. On September 23 (regularly scheduled monthly call) be prepared to discuss/present the core elements of your group's program(s).

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Questions to help get to what is meant by core elements ...

Q1. Overview of the program/model/framework/approach
Q2. Where and how it has been used (or will be used)
Q3. Evaluation plans or findings
Q4. Take-aways and lessons learned

Community-Based Suicide Prevention Leadership Group: Meeting Notes

July 8, 2016
2 PM Eastern/11 AM Pacific

Attendees:

Co-leads: Bob Gebbia, Jim Mercy, Jerry Reed,
Staff: Maggie Labre, Liliya Melnyk, Christine Moutier, Jason H. Padgett, Deb Stone, Elly Stout

1. Assignment of Programs and Models

At the June 24 meeting, the group had suggested dividing the programs/models in the background document among participants, so that they could distill key elements/highlights and make brief presentations to the group. However, the background document includes a long list of items—some of which are not specifically focused on community-based suicide prevention (e.g., NREPP individual programs). Should all of these be covered via presentations?

- Our document should focus more on the higher-level strategies that are needed for comprehensive, integrated suicide prevention in communities—not on individual programs.
- NREPP programs should be referenced in the document in some way—for example, in the resources section—but do not require a presentation.
- Our document needs to provide the guidance communities need to carry out comprehensive suicide prevention—for example, how to assess the burden, identify champions in the community, select evidence-based strategies, evaluate, and monitor.
- The document should identify the steps, emphasize the value of a comprehensive approach, and identify resources. Once this broad guidance is finalized, we can develop toolkits, resources, trainings, and other ways to pull everything together. The first step is to distill the key elements.
- How do we ensure that the document will be useful to diverse communities? The document will outline the broad, macro-level elements required for comprehensive, integrated suicide prevention. These elements would be translatable for adoption by diverse communities.

2. Identifying Fundable Projects

By the October EXCOM meeting, the Action Alliance would like to identify ideas for fundable opportunities—strategic fundable initiatives that would help advance its three priority areas (e.g., a toolkit for communities, a community suicide prevention website). The funding could come from the public or private sectors.

- Questions to think about: What are the high-priority investments that we should be making now to move the field forward? What is not happening in the field where the Action Alliance could make a big difference? Within the three priorities, what are the things that lend themselves to lead to tangible deliverables that can get community support?
- If a donor was interested in supporting concrete project, our approach would be to put it out in a simple grant mechanism, so organizations most interested in implementing the project could apply and then the one most suited to do the work would do it.
- What kind of donor would want to fund community-based suicide prevention? We may want to focus on different settings in the community—for example, the workplace setting (e.g., the occupational settings identified in the recent CDC paper—such as construction and farming). Most donors want something specific.
- Strategic fundable initiative ideas:
    - Build a website/toolkit re: comprehensive/integrated CBSP ($150,000)
    - Develop a Community of Practice/pilot group to test usefulness ($500,000?)
    - Means reduction summit/efforts campaign ($750,000)
    - Workplace setting efforts—focusing on occupational industry; faith community
    - Community convener for community industries/leaders/etc.
    - President's Budget proposed items

3. Action Items and Next Steps

- Maggie and Jason to work on draft and assignments/instructions.
- Send additional fundable ideas to Jason as you think of them.
- Next full CBSP group meeting, **Friday, July 22, 2016, at 2 pm** Eastern/11am Pacific, will focus on the CDC Technical Package.
- Next CBSP leadership meeting, Friday, August 12, 2016 at 2pm Eastern/11am Pacific.

From: Padgett, Jason
Sent: 24 Oct 2016 13:37:50 +0000
To: Mercy, James (CDC/ONDIEH/NCIPC);Reed, Jerry;Robert Gebbia
Cc: cmoutier@afsp.org;Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;(b)(6);Rachel Caraballo
Subject: Decision requested: Action Alliance: Community-based Suicide Prevention Full Group Call

Good morning all,

BLUF: Maintain, cancel or change purpose of Friday's scheduled meeting of the Transforming Communities group.

First, many thanks to Bob, Jim, and Jerry for presenting at the EXCOM meeting last week. Second, much appreciation to all of you for moving efforts forward over the past few months. As you may see on your calendars, we have a full group call scheduled for Friday afternoon. However, I think our only information to share/discuss at this point could be a brief summary about activity since the face-to-face meeting (desire to align with CDC Technical package release; gain more input from community leaders such as a few AFSP chapters or few communities within states). Therefore, I am wondering which of the following this you, as the co-leads, would prefer:

a. Maintain scheduled meeting and keep it brief
b. Change it to a leadership meeting to better plot out alignment and input gathering
c. Cancel it which would allow for time to prepare a plan for gathering input and aligning with CDC technical package.

Please let me know if you prefer A, B, or C. **I lean towards/recommend C.** However, I can make a case for B, as well as A. Once I hear back from a few and (if) there appears to be alignment, I'll update the full group.

Either way, we'll need to extend meetings of the leadership team and full group a few months to complete the work.

Kindly,
-Jason

Jason H. Padgett, MPA, MSM
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EDC Learning transforms lives.

From: Hindman - CDPHE, Jarrod
Sent: 29 Nov 2017 16:32:26 -0700
To: Sarah Brummett - CDPHE;Gutierrez, Peter M. <Peter.Gutierrez@va.gov>;Brian Turner;Ethan Jamison - CDPHE;Bol, Kirk;Emily Fine - CDPHE;Barb Becker;Gebbia, Robert;Schoenbaum, Michael (NIH/NIMH) [C];McKeon, Richard (SAMHSA/CMHS);Crosby, Alexander (CDC/ONDIEH/NCIPC);Quinlan, Kristen;Caine, Eric;Reed, Jerry;White, AnnMarie;Conwell, Yeates;Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Cc: Kyle Brown - GovOffice;Betz, Marian;Allen, Michael;Runyan, Carol
Subject: Detailed agendas
Attachments: 2017-12-05-Agenda-El Paso County-Detailed.docx, 2017-12-05-Agenda-Pueblo County-Detailed.docx, 2017-12-06-Agenda-Larimer County-Detailed.docx

Attached. Let me know what I've missed and/or what needs to be amended.

Alex / Shakiyla - Can one of you present on the Technical Package?
Jerry / Bob - Can one of you present on the Transforming Communities doc?
Ethan / Kirk - note the data presentation section and let me know if anything needs to be tweaked.

FYI. . . I just sent these to local partner leaders as well, so there may be some adjustments. I'll keep you posted if so.

Thank you.

Jarrod

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Jarrod Hindman, MS
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Colorado National Collaborative (CNC) & El Paso County
Partner Meeting for Comprehensive Suicide Prevention
El Paso County Partner Meeting
December 5, 2017 – 8:30am - Noon
Penrose House, 1661 Mesa Avenue, Colorado Springs, CO 80906

El Paso County partners that have RSVP'd (~20) include local PH (including SIM and CTC), the Suicide Prevention Partnership (local suicide prevention non-profit), the faith community, Penrose and Memorial hospitals, AspenPointe (CMHC), 2 school districts, Fort Carson, VA, Kaiser Permanente, and the Coroner's Office

Intended Outcomes:

- Discuss available El Paso County suicide data and other indicators of premature mortality and morbidity
- Identify populations being reached and those being missed. What is needed to achieve a 20% suicide reduction by 2024?
- Describe and discuss current local, state, and national priorities for suicide prevention
- Consider overlap with other prevention efforts (e.g., opioid use; sexual and intimate partner violence)
- Discuss shared priorities and explore partnership opportunities
- Explore the potential intersections between local, state and national partners
- Define and agree on next steps

AGENDA *(State and national partners arrive between 8-8:15)*

8:30 – 8:50 – Introductions *(Janet, Kelsey and/or Dan, and Jarrod)*

- What agency do you represent and what would it take for you to leave this meeting today feeling as though your time was effectively spent? *(1-2 sentences – kickoff by asking people to create space for everyone's voice to be heard)*
- What is the CNC? *(Eric, Jarrod and/or Jerry – 5 min)*

8:50 – 9:20 – Data

- Local data (Local public health, coroner's office, CMHC, VA, other) *(Dr. Kelly, Coroner's Office - ~ 10 min)*
- State data (NVDRS data dashboard, other) *(Ethan – Dashbrd, death cert, hosp and ED discharge - ~ 10 min)*
- Discussion

9:20 - 10:00 - Local Priorities, Activities and Partners

- Local leader presentation *(Janet, Meghan / Kelsey, Fort Carson, Aspen Pointe, Sarah – GLS - ~ 20 min)*
- CNC community inventory and partner list *(Kristen Quinlan lead - ~ 15 min)*
- Discussion

10:00 – 10:15 – Break

10:15 – 10:45 – State and National Priorities and Activities

- CNC priorities *(Jarrod, Eric – 10 min)*
- CDC Technical Package *(Alex, Shakiyla? – 10 min)*
- National Action Alliance for Suicide Prevention Transforming Communities Guide *(Jerry, Bob? – 10 min)*

10:45 – 11:45 – Shared Priorities Discussion *(Facilitated by Jarrod, Janet, Kelsey)*
(Facilitated discussion – Rotating small groups focusing on priorities – youth (0-18), young adults (19-25), adults (25-64), veterans/military, older adults (65+), health care systems. For each, list priorities, key partners, key data sources (existing and missing). Brainstorm and capture ideas on flip chart paper or sticky note. Rotate to each priority as a group every 5 minutes, adding to list started by previous group (30 min). Quick and broad debrief w/ full group (10 min). Dot-polling (1 per priority or 3 or 4 total across all priorities) to identify initial priorities and partnership opportunities, followed by discussion / agreements (20 min))

- What are our shared priorities?
- Who are key partners, and who is missing?
- How do we currently measure results?
- Are there key gaps?
- Can we partner?

11:45 – Noon – Agreements and Next Steps (*Facilitated by Jarrod)*

Colorado National Collaborative (CNC) & Pueblo County
Partner Meeting for Comprehensive Suicide Prevention
Pueblo County Partner Meeting
December 5, 2017 – 1:00pm – 5:00pm
Sycare, 1740 Eagleridge Blvd, Pueblo, CO 81008

Pueblo partners that have RSVP'd (~ 20) include school districts, local public health (including SIM and CTC), local community MH center, law enforcement, a retired judge, Park View and St. Mary Corwin hospitals

Intended Outcomes:

- Discuss available Pueblo County suicide data and other indicators of premature mortality and morbidity
- Identify populations being reached and those being missed. What is needed to achieve a 20% suicide reduction by 2024?
- Describe and discuss current local, state, and national priorities for suicide prevention
- Consider overlap with other prevention efforts (e.g., opioid use; sexual and intimate partner violence)
- Discuss shared priorities and explore partnership opportunities
- Explore the potential intersections between local, state and national partners
- Define and agree on next steps

AGENDA

1:00 – 1:30 – Lunch and networking *(State and national partners arrive between 1-1:15)*

1:30 – 1:50 – Introductions *(Kristie Dorwart, Jarrod Hindman)*

- What agency do you represent and what would it take for you to leave this meeting today feeling as though your time was effectively spent? *(1-2 sentences – kickoff by asking people to create space for everyone's voice to be heard)*
- What is the CNC? *(Eric, Jarrod and/or Jerry – 5 min)*

1:50 – 2:20 – Data

- Local data (Local public health, coroner's office, CMHC, VA, other) *(Kristie – very brief update on 2017 data?)*
- State data (NVDRS data dashboard, other) *(Ethan Jamison – Ethan, there will not be a local data presentation, so please present dashboard, death cert, hospital, ED, etc. for Pueblo County - ~ 15 min)*
- Discussion

2:20 - 3:00 - Local Priorities, Activities and Partners

- Local leader presentation *(More discussion – Kristie, SIM, CTC, Zero Suicide, Sarah – GLS - ~15 min)*
- CNC community inventory and partner list *(Kristen Quinlan lead - ~ 15 min)*
- Discussion

3:00 – 3:15 – Break

3:15 – 3:45 – State and National Priorities and Activities

- CNC priorities *(Jarrod, Eric – 10 min)*
- CDC Technical Package *(Alex, Shakiyla? – 10 min)*
- National Action Alliance for Suicide Prevention Transforming Communities Guide *(Jerry, Bob? – 10 min)*

3:45 – 4:45 – Shared Priorities Discussion *(Facilitated by Jarrod, Kristie)*
(Facilitated discussion – Rotating small groups focusing on priorities – youth (0-18), young adults (19-25), adults 25-64), veterans/military, older adults (65+), health care systems. For each, list priorities, key partners, key data sources (existing and missing). Brainstorm and capture ideas on flip chart paper or sticky note. Rotate to each priority every 5 minutes, adding to list started by previous group (30 min). Quick and broad debrief w/ full group (10 min). Dot-polling (1 per priority or 3 or 4 total across all priorities) to identify initial priorities and partnership opportunities, followed by discussion / agreements (20 min))

- What are our shared priorities?
- Who are key partners, and who is missing?
- How do we currently measure results?
- Are there key gaps?
- Can we partner?

4:45 – 5:00 – Agreements and Next Steps *(Facilitated by Jarrod, Kristie)*

Colorado National Collaborative (CNC) & Larimer County
Partner Meeting for Comprehensive Suicide Prevention
Larimer County Partner Meeting
December 6, 2017 – 8:30am - Noon
Pathways Hospice, Community Room, 305 Carpenter Road, Fort Collins, CO 80525

Larimer County partners that have RSVP'd (~35!) include the local Imagine Zero team, Summit Stone (CMHC), North Range Behavioral Health (CMHC), local public health, 2 school districts, an LGBTQ organization, Colorado State University, law enforcement, State Senator John Kefalas, a local veterans group, and criminal justice

Intended Outcomes:

- Discuss available Larimer County suicide data and other indicators of premature mortality and morbidity
- Identify populations being reached and those being missed. What is needed to achieve a 20% suicide reduction by 2024?
- Describe and discuss current local, state, and national priorities for suicide prevention
- Consider overlap with other prevention efforts (e.g., opioid use; sexual and intimate partner violence)
- Discuss shared priorities and explore partnership opportunities
- Explore the potential intersections between local, state and national partners
- Define and agree on next steps

AGENDA *(State and national partners arrive between 8-8:15)*

8:30 – 8:50 – Introductions *(Amanda, Jarrod)*

- Name and agency you represent *(Kelsey will ask RSVP list to respond via email what it would take for them to leave the meeting feeling as though their time would be effectively spent. Remind people to create space for everyone's voice to be heard)*
- What is the CNC *(Eric, Jarrod and/or Jerry – 5 min)*

8:50 – 9:20 – Data

- Local data (Local public health, coroner's office, CMHC, VA, other) *(Maybe? Kiley checking with Coroner's Office)*
- State data (NVDRS data dashboard, other) (*Kirk – Dashbrd, death cert, hosp and ED discharge - ~ 10-15 min)*
- Discussion

9:20 - 10:00 - Local Priorities, Activities and Partners

- Local leader presentation *(Rachel, Sarah – GLS - ~ 15-20 min)*
- CNC community inventory and partner list *(Kristen Quinlan lead - ~ 15 min. May be able to trim if RSVP list responds via email prior to meeting)*
- Discussion

10:00 – 10:15 – Break

10:15 – 10:45 – State and National Priorities and Activities

- CNC priorities *(Jarrod, Eric – 10 min)*
- CDC Technical Package *(Alex, Shakiyla? – 10 min)*
- National Action Alliance for Suicide Prevention Transforming Communities Guide *(Jerry, Bob? – 10 min)*

10:45 – 11:45 – Shared Priorities and Action Steps Discussion *(Facilitated by Jarrod, Rachel, Amanda – Amanda, introduce / quickly highlight systems mapping as a potential priority next step)*

(Facilitated discussion – Rotating small groups focusing on priorities and ACTION STEPS – youth (0-9), Youth (10-18), young adults (19-25), adults (25-64), older adults (65+), health care systems. For each, list action steps (and priorities if missing), key partners, and key data sources (existing and missing). Brainstorm and capture ideas on flip chart paper or sticky notes. Rotate to each priority as a group every 5 minutes, adding to list started by previous group (30 min). Quick and broad debrief w/ full group (10 min). Dot-polling (1 per priority or 3 or 4 total across all priorities) to identify initial priorities and partnership opportunities, followed by discussion / agreements (20 min))

- What are our shared priorities?
- Who are key partners, and who is missing?
- How do we currently measure results?
- Are there key gaps?
- Can we partner?

11:45 – Noon – Agreements and Next Steps

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 10:03:47 -0400
To: Torguson, Kimberly;Belyeu, Avery;jbenson@reingold.com;Bray, Miranda (SAMHSA/OC);Sam.Brinton@thetrevorproject.org;Bruce, Crystal (CDC/OPHPR/OD);Carr, Colleen;SCoggin@afsp.org;ccreighton@suicidology.org;Crosby, Alexander (CDC/ONDIEH/NCIPC);Curtin, Sally C. (CDC/OPHSS/NCHS);Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Ashby.Dodge@thetrevorproject.org;mgdyak@eiconline.org;JohnD@mhaofnyc.org;fgonzalez@mhaofnyc.org;Gass, Jesse;Hausman, Bridgette;Hedegaard, Holly (CDC/OPHSS/NCHS);Holland, Kristin (CDC/ONDIEH/NCIPC);ajkulp@suicidology.org;Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);wendy.e.lakso.civ@mail.mil;plauricella@reingold.com;sheri.lunn@thetrevorproject.org;cmaxwell@suicidology.org;McElroy, James (NIH/NIMH) [E];McShane, Kristen (SAMHSA/OC);steve.mendelsohn@thetrevorproject.org;eneely@reingold.com;AOBrien@afsp.org;O'Keefe, Lindsey (NIH/NIMH) [E];Amit.Paley@thetrevorproject.org;jpearson@nih.gov;Pearson, Jane L (NIH/NIMH) [E];Reed, Jerry;dreidenberg@save.org;Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);mrosen@mhaofnyc.org;michaelle.scanlon@nih.gov;Sobottka, Linda;Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;calvin.stowell@thetrevorproject.org;AVactor@mhaofnyc.org;Warner, Margaret (CDC/OPHSS/NCHS);katherine.v.warrick.civ@mail.mil;kevin.wong@thetrevorproject.org;Wright, James (SAMHSA/DPTSSP)
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
Attachments: FACT SHEET_Vital Signs_June_2018_Suicide_Final_WEB.PDF

In prep for our call today to discuss our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* attached is an **embargoed** copy of the Fact Sheet. The Vital Signs includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions. We appreciate this partnership and hope you can all help us disseminate the Vital Signs to your networks once the **embargo lifts at 1:00 pm**.
Erin
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The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.
This e-mail contains an advance copy of the four-page *Vital Signs* fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; the attachment is EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each

- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition

- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).
Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

-----Original Appointment-----
From: Torguson, Kimberly
Sent: Monday, May 14, 2018 6:59 PM
To: Torguson, Kimberly; Belyeu, Avery; jbenson@reingold.com; Black, Erin (CDC/ONDIEH/NCIPC); Bray, Miranda (SAMHSA/OC); Sam.Brinton@thetrevorproject.org; Bruce, Crystal (CDC/OPHPR/OD); Carr, Colleen; SCoggin@afsp.org; ccreighton@suicidology.org; Crosby, Alexander (CDC/ONDIEH/NCIPC); Curtin, Sally C. (CDC/OPHSS/NCHS); Daniel, Valerie M. (CDC/ONDIEH/NCIPC); Ashby.Dodge@thetrevorproject.org; mgdyak@eiconline.org; JohnD@mhaofnyc.org; fgonzalez@mhaofnyc.org; Gass, Jesse; Hausman, Bridgette; Hedegaard, Holly (CDC/OPHSS/NCHS); Holland, Kristin (CDC/ONDIEH/NCIPC); ajkulp@suicidology.org; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC); wendy.e.lakso.civ@mail.mil; plauricella@reingold.com; sheri.lunn@thetrevorproject.org; cmaxwell@suicidology.org; McElroy, James (NIH/NIMH) [E]; McShane, Kristen (SAMHSA/OC); steve.mendelsohn@thetrevorproject.org; eneely@reingold.com; AOBrien@afsp.org; O'Keefe, Lindsey (NIH/NIMH) [E]; Amit.Paley@thetrevorproject.org; jpearson@nih.gov; Pearson, Jane L (NIH/NIMH) [E]; Reed, Jerry; dreidenberg@save.org; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); mrosen@mhaofnyc.org; michaelle.scanlon@nih.gov; Sobottka, Linda; Stone, Deborah (CDC/ONDIEH/NCIPC); Stout, Elly; calvin.stowell@thetrevorproject.org; AVactor@mhaofnyc.org; Warner, Margaret (CDC/OPHSS/NCHS); katherine.v.warrick.civ@mail.mil; kevin.wong@thetrevorproject.org; Wright, James (SAMHSA/DPTSSP)
Subject: Media Messaging Work Group Call
When: Thursday, June 7, 2018 11:00 AM-11:30 AM (UTC-05:00) Eastern Time (US & Canada).
Where: Phone Number: 866-370-2808 (access code (b)(6
Phone Number: 866-370-2808 (access code (b)(6
Email Context (From 5/14):
Hello Media Messaging Work Group (MMWG),
Following the email below, we wanted to let you know that the CDC data expected to be released on June 5 will **now be released on June 7**. Additionally, we received word that we will not be receiving an embargoed copy so we'll be rescheduling our MMWG group call (originally scheduled for Thursday, May 31) to **Thursday, June 7 at 11:00 a.m.**

The goal of this call is to convene our partners to: 1) discuss the data, and 2) develop consensus on our messaging that will be used to craft a statement. If you are unable to join the call, you will still have the opportunity to weigh in on the statement via email.

We hope you can join us on Thursday, June 7 at 11:00 a.m.
Lastly, we want to thank CDC for giving us the heads up about the data.
Best,

Hello Media Messaging Work Group,
We wanted to call to your attention to a just-released article published in the *American Journal of Preventive Medicine* that looks at county-specific estimates of suicide rates. The paper titled "County-level Trends in Suicide Rates in the U.S., 2005-2015" was written by our Partner, CDC (authors include: Lauren M. Rossen, Holly Hedegaard, Diba Khan and Margaret Warner from NCHS).
Key findings include:

- Posterior predicted mean county-level suicide rates increased by >10% from 2005 to 2015 for 99% of counties in the U.S., with 87% of counties showing increases of >20%.
- Counties with the highest model-based suicide rates were consistently located across the western and northwestern U.S., with the exception of southern California and parts of Washington.
- Compared with more urban counties, more rural counties had the highest estimated suicide rates from 2005 to 2015, and also the largest increases over time.

Overall the data underscores the importance of looking at geographic areas to identify high risk and need for more coordinated and comprehensive community-based suicide prevention efforts in the U.S.
While the Action Alliance does notplan to put out a formal statement about the data at this time, we encourage you to reference our past collective statement (written in collaboration with the MMWG partners) released last year that looks at suicide rates in urban and rural areas. You'll notice much of the information is very relevant and timely as it relates to the county-level trends data.
Please find below some tailorable social media posts to help further promote the data:

- Data released by @CDCInjury featured in @AmJPrevMed shows county-level trends in suicide rates in the US http://bit.ly/2IHo6hk
- New article featured in @AmJPrevMed underscores need for coordinated and comprehensive community-based suicide prevention efforts http://bit.ly/2IHo6hk
- Trends about suicide, like geographic patterns, helps us develop more targeted community-based #suicideprevention strategies http://bit.ly/2IHo6hk so we can reduce annual suicide rate 20% by 2025
- Rural counties in the U.S. had the highest estimated suicide rates from 2005-2015 according to just-released @AmJPrevMed http://bit.ly/2IHo6hk
- Tracking county-level suicide rates helps our field to better understand changes in suicide rates over time and develop more targeted suicide prevention efforts http://bit.ly/2IHo6hk
- Together we can reduce the annual suicide rate 20 percent by 2025 but we need continued research on community-level risk and protective factors as shown in recent data by @CDCinjury http://bit.ly/2IHo6hk

When posting, please consider incorporating Media Messaging Work Group Partner Twitter handles:

- @Action_Alliance
- @AASuicidology
- @afspnational
- @CDCInjury
- @CDCMMWR
- @DeptofDefense
- @DeptVetAffairs
- @EDCTweets
- @NIH

- @NIMHgov
- @ReingoldInc
- @samhsagov
- @SAVEvoicesofedu
- @SPRCtweets
- @TrevorProject
- @800273TALK

Some resources that you may also find helpful as you promote the data include:

- **Action Alliance's *Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention*** – A resource that outlines strategic components that should guide program planning and implementation at the community level.
- ***CDC's Preventing Suicide: A Technical Package of Policy, Programs, and Practices*** – A resourcethat helps states and communities prioritize efforts to prevent suicide.

We wanted to give you all the heads up that CDC is also expected to release additional relevant data to inform suicide prevention efforts on or around June 5th. The Action Alliance Secretariat does plan to convene this group to develop consensus messaging around this impending data release. In preparation for this larger data release, we'll be convening the MMWG for a call in late May to discuss the data and our collective statement.

REQUEST: Please join us for a planning call on Thursday, May 31 at 2:00 p.m. ET to plan ahead for collective statement about CDC data.

We will send you a calendar invite (containing call-in information) to you shortly. If you are unable to participate on this call, you'll have the opportunity to weigh in on the statement electronically.

Lastly, we wanted to thank CDC for giving us the heads up about the data.

Thank you.

#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



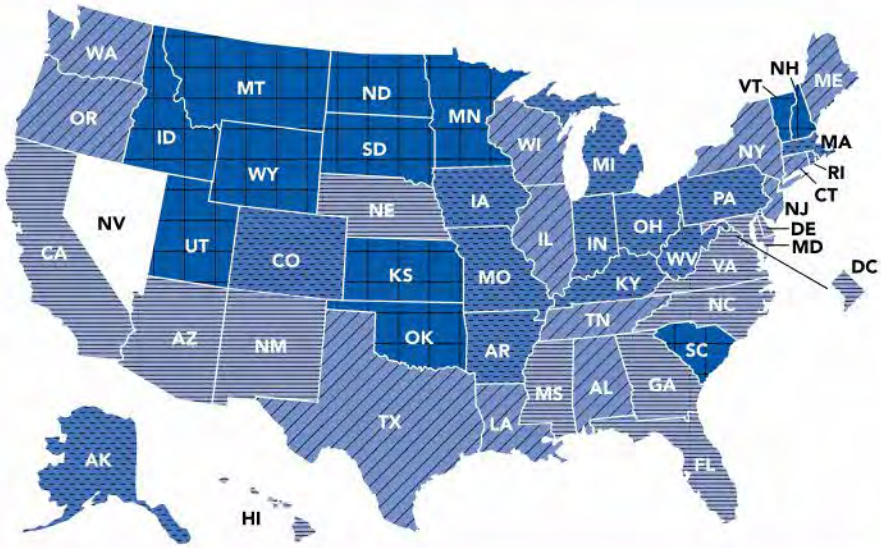
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

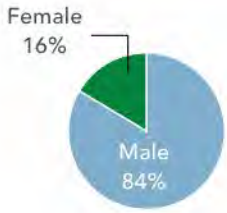


Differences exist among those with and without mental health conditions.

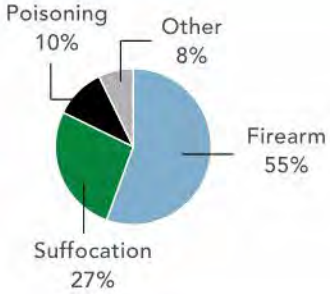
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

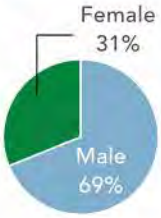


Method

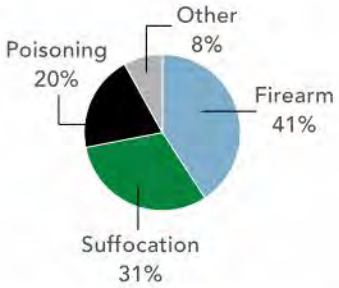


Known mental health conditions

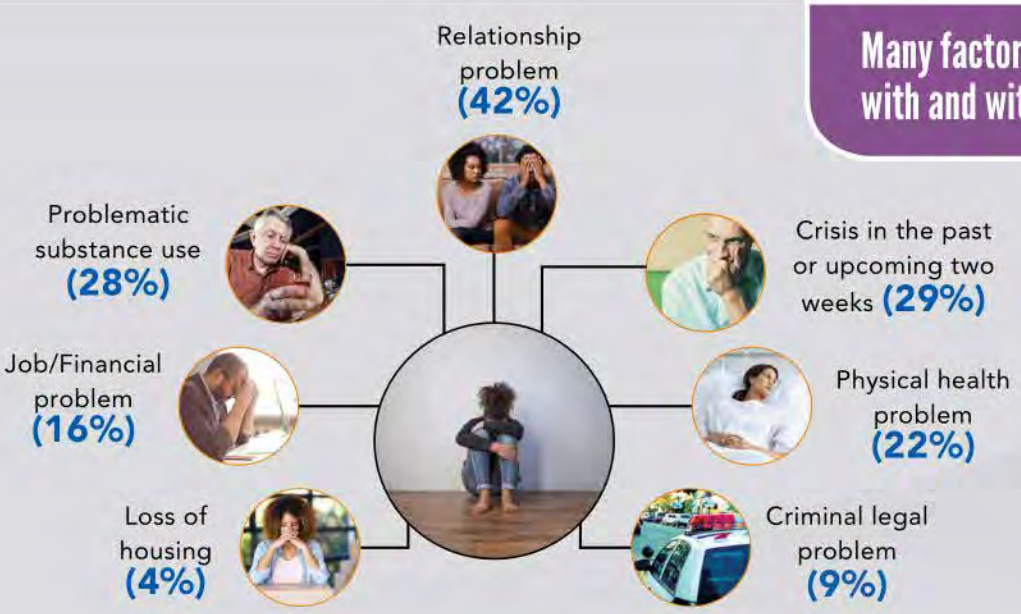
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018

From: Doyle, Nadine (CDC/ONDIEH/NCIPC)
Sent: 27 Jun 2016 08:17:34 -0400
To: Robert Gebbia;Christine Moutier;McMillen, John
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC);Reimels, Elizabeth (CDC/ONDIEH/NCIPC);Doyle, Nadine (CDC/ONDIEH/NCIPC)
Subject: Head's Up: New CDC Report on Suicide by Occupation

Good morning Bob, Christine, and John,
I hope you guys are well! It's been wonderful to collaborate more closely over the past several months – Beth and Jim tell me that you all had a productive visit up in NYC a few months ago, and we truly appreciated the opportunity to have Beth speak at your Advocacy Day a few weeks ago. I'm not sure if Beth has told you, but she will be going on temporary detail to CDC's Office on Smoking and Health for the next four months; in the meantime, I will remain your primary point of contact and look forward to continuing the discussions we've begun!
In the spirit of continued coordination and information sharing, I wanted to let you know in advance about an upcoming article in MMWR, which will be titled **Suicide by Occupation – 17 States, 2012**. This article will be released on Thursday, June 30, 2016 at 1 pm ET. The data have been pulled from the National Violent Death Reporting System, and the report analyzes suicide deaths for those over the age of 16 by sex and occupation.

The key findings from the report (which I unfortunately can't share outside the agency yet) will include the highest rates of suicide by occupational categories. These findings can help employers and suicide prevention professionals know who may need to be reached by suicide prevention activities.

I appreciate you keeping this information about this article within your organization until the report is officially released (Thursday, June 30, 2016 at 1 pm ET), but hope you will consider joining the conversation after the release date by:

- Sharing a message on social media:
    - o New CDC report analyzes highest suicide rate by occupation and sex. #VetoViolence
    - o Results from new CDC report can help target suicide prevention work to certain occupations. #VetoViolence
- Forwarding the upcoming partner announcement through email
- Sending questions about the report to dvpinquiries@cdc.gov

Thank you for all of your work to prevent suicides and help people live their lives to their fullest potential!
Nadine Doyle, MPA
Policy and Partnerships Team
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Office #: 770-488-1316
Mobile #: 404-394-4307
Telework Tuesdays & Wednesdays; Out of Office Fridays

To: Torguson, Kimberly;Belyeu, Avery;jbenson@reingold.com;Black, Erin (CDC/ONDIEH/NCIPC);Bray, Miranda (SAMHSA/OC);Sam.Brinton@thetrevorproject.org;Bruce, Crystal (CDC/OPHPR/OD);Carr, Colleen;SCoggin@afsp.org;ccreighton@suicidology.org;Crosby, Alexander (CDC/ONDIEH/NCIPC);Curtin, Sally C. (CDC/OPHSS/NCHS);Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Ashby.Dodge@thetrevorproject.org;mgdyak@eiconline.org;JohnD@mhaofnyc.org;fgonzalez@mhaofnyc.org;Gass, Jesse;Hausman, Bridgette;Hedegaard, Holly (CDC/OPHSS/NCHS);Holland, Kristin (CDC/ONDIEH/NCIPC);ajkulp@suicidology.org;Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);wendy.e.lakso.civ@mail.mil;plauricella@reingold.com;sheri.lunn@thetrevorproject.org;cmaxwell@suicidology.org;McElroy, James (NIH/NIMH) [E];McShane, Kristen (SAMHSA/OC);steve.mendelsohn@thetrevorproject.org;eneely@reingold.com;AOBrien@afsp.org;O'Keefe, Lindsey (NIH/NIMH) [E];Amit.Paley@thetrevorproject.org;jpearson@nih.gov;Pearson, Jane L (NIH/NIMH) [E];Reed, Jerry;dreidenberg@save.org;Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);mrosen@mhaofnyc.org;michaelle.scanlon@nih.gov;Sobottka, Linda;Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;calvin.stowell@thetrevorproject.org;AVactor@mhaofnyc.org;Warner, Margaret (CDC/OPHSS/NCHS);katherine.v.warrick.civ@mail.mil;kevin.wong@thetrevorproject.org;Wright, James (SAMHSA/DPTSSP)
Subject: Media Messaging Work Group Call
Attachments: Media Messaging Work Group Call .msg

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tart: Thu 6/7/2018 11:00 AM

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From: Torguson, Kimberly
Sent: 14 May 2018 22:58:33 +0000
To: Torguson, Kimberly;Belyeu, Avery;jbenson@reingold.com;Black, Erin (CDC/ONDIEH/NCIPC);Bray, Miranda (SAMHSA/OC);Sam.Brinton@thetrevorproject.org;Bruce, Crystal (CDC/OPHPR/OD);Carr, Colleen;SCoggin@afsp.org;ccreighton@suicidology.org;Crosby, Alexander (CDC/ONDIEH/NCIPC);Curtin, Sally C. (CDC/OPHSS/NCHS);Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Ashby.Dodge@thetrevorproject.org;mgdyak@eiconline.org;JohnD@mhaofnyc.org;fgonzalez@mhaofnyc.org;Gass, Jesse;Hausman, Bridgette;Hedegaard, Holly (CDC/OPHSS/NCHS);Holland, Kristin (CDC/ONDIEH/NCIPC);ajkulp@suicidology.org;Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);wendy.e.lakso.civ@mail.mil;plauricella@reingold.com;sheri.lunn@thetrevorproject.org;cmaxwell@suicidology.org;McElroy, James (NIH/NIMH) [E];McShane, Kristen (SAMHSA/OC);steve.mendelsohn@thetrevorproject.org;eneely@reingold.com;AOBrien@afsp.org;O'Keefe, Lindsey (NIH/NIMH) [E];Amit.Paley@thetrevorproject.org;jpearson@nih.gov;Pearson, Jane L (NIH/NIMH) [E];Reed, Jerry;dreidenberg@save.org;Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);mrosen@mhaofnyc.org;michaelle.scanlon@nih.gov;Sobottka, Linda;Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;calvin.stowell@thetrevorproject.org;AVactor@mhaofnyc.org;Warner, Margaret (CDC/OPHSS/NCHS);katherine.v.warrick.civ@mail.mil;kevin.wong@thetrevorproject.org;Wright, James (SAMHSA/DPTSSP)
Subject: Media Messaging Work Group Call

Phone Number: 866-370-2808 (access code (b)(6)
Email Context (From 5/14):
Hello Media Messaging Work Group (MMWG),
Following the email below, we wanted to let you know that the CDC data expected to be released on June 5 will **now be released on June 7**. Additionally, we received word that we will not be receiving an embargoed copy so we'll be rescheduling our MMWG group call (originally scheduled for Thursday, May 31) to **Thursday, June 7 at 11:00 a.m.**

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We hope you can join us on Thursday, June 7 at 11:00 a.m.
Lastly, we want to thank CDC for giving us the heads up about the data.
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Key findings include:

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- Compared with more urban counties, more rural counties had the highest estimated suicide rates from 2005 to 2015, and also the largest increases over time.

Overall the data underscores the importance of looking at geographic areas to identify high risk and need for more coordinated and comprehensive community-based suicide prevention efforts in the U.S. While the Action Alliance does notplan to put out a formal statement about the data at this time, we encourage you to reference our past collective statement (written in collaboration with the MMWG partners) released last year that looks at suicide rates in urban and rural areas. You'll notice much of the information is very relevant and timely as it relates to the county-level trends data.

Please find below some tailorable social media posts to help further promote the data:

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- Tracking county-level suicide rates helps our field to better understand changes in suicide rates over time and develop more targeted suicide prevention efforts http://bit.ly/2IHo6hk
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- @AASuicidology
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Subject: Media Messaging Work Group Call
Attachments: Media Messaging Work Group Call .msg

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ocation: Phone Number: 866-370-2808 (access code (b)(

tart: Thu 6/7/2018 11:00 AM

nd: Thu 6/7/2018 12:00 PM

how Time As: Tentative

ecurrence: (none)

eeting Status: Not yet responded

rganizer: Torguson, Kimberly

Phone Number: 866-370-2808 (access code (b)(

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From: Torguson, Kimberly
Sent: 29 May 2018 15:18:15 +0000
To: Torguson, Kimberly;Belyeu, Avery;jbenson@reingold.com;Black, Erin (CDC/ONDIEH/NCIPC);Bray, Miranda (SAMHSA/OC);Sam.Brinton@thetrevorproject.org;Bruce, Crystal (CDC/OPHPR/OD);Carr, Colleen;SCoggin@afsp.org;ccreighton@suicidology.org;Crosby, Alexander (CDC/ONDIEH/NCIPC);Curtin, Sally C. (CDC/OPHSS/NCHS);Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Ashby.Dodge@thetrevorproject.org;mgdyak@eiconline.org;JohnD@mhaofnyc.org;fgonzalez@mhaofnyc.org;Gass, Jesse;Hausman, Bridgette;Hedegaard, Holly (CDC/OPHSS/NCHS);Holland, Kristin (CDC/ONDIEH/NCIPC);ajkulp@suicidology.org;Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);wendy.e.lakso.civ@mail.mil;plauricella@reingold.com;sheri.lunn@thetrevorproject.org;cmaxwell@suicidology.org;McElroy, James (NIH/NIMH) [E];McShane, Kristen (SAMHSA/OC);steve.mendelsohn@thetrevorproject.org;eneely@reingold.com;AOBrien@afsp.org;O'Keefe, Lindsey (NIH/NIMH) [E];Amit.Paley@thetrevorproject.org;jpearson@nih.gov;Pearson, Jane L (NIH/NIMH) [E];Reed, Jerry;dreidenberg@save.org;Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);mrosen@mhaofnyc.org;michaelle.scanlon@nih.gov;Sobottka, Linda;Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;calvin.stowell@thetrevorproject.org;AVactor@mhaofnyc.org;Warner, Margaret (CDC/OPHSS/NCHS);katherine.v.warrick.civ@mail.mil;kevin.wong@thetrevorproject.org;Wright, James (SAMHSA/DPTSSP)
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From: Belyeu, Avery
Sent: 6 Apr 2017 14:58:19 +0000
To: Caraballo, Rachel;Reed, Jerry;Bird, Doreen;Carr, Colleen;mruhe@naccho.org;Mercy, James (CDC/ONDIEH/NCIPC);Robert Gebbia;Magdala Labre;Stone, Deborah (CDC/ONDIEH/NCIPC);CMoutier@afsp.org;Stout, Elly;heidi@heidibryan.com;edemello@naminh.org;jarrod.hindman@state.co.us;Annmarie_white@urmc.rochester.edu;Zeller, Eileen (SAMHSA/CMHS);Dr. John Harrison;Heather.Stokes@livingworks.net;gigi@gcolombini.com;Ken Norton;bprice@cadca.org;Melissa Helm;Johnson, Brandon J. (SAMHSA/CMHS);Torguson, Kimberly
Subject: National Action Alliance: Transforming Communities Paper Release
Attachments: Action Alliance Press Release_Transforming Communities_Final.docx

Dear Community-Based Suicide Prevention Working Group,
We are pleased to share with you the final **Transforming Communities paper** and corresponding promotional materials. We thank you for all of your ideas and contributions to the materials and look forward to working with you to jointly promote.
The Action Alliance will be distributing the press release and email announcement **today (4/6) at 11:00 a.m. ET.**

We encourage you to also share the press release with media contacts as well as promote via your various channels. Please use the following link when promoting: http://bit.ly/_Communities.
(Additionally, we've attached a Word version in the case you need pieces of content for various communication channels.)

Below, please find an email announcement (which mentions the April 12th webinar) to share widely across your various listservs and contact lists.
Lastly, please find a few tailorable social media posts below for your convenience. Feel free to tweak as needed as well as retweet/like the Action Alliance's social media posts.

Twitter:

- Today national groups collectively release resources to help communities prioritize #suicideprevention http://bit.ly/_Communities @action_alliance @afspnational @sprctweets @cdcgov
- New resources to guide community-based suicide prevention http://bit.ly/_Communities @action_alliance @afspnational @sprctweets @cdcgov
- Just-released TWO new tools to help communities comprehensively address suicide http://bit.ly/_Communities @action_alliance @afspnational @sprctweets @cdcgov

Facebook:

- Today, the Action Alliance and its partners including the American Foundation for Suicide Prevention, Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration's Suicide Prevention Resource Center (SPRC) collectively released two new resources that synthesize current knowledge about community-based suicide prevention and emphasize the need for comprehensive efforts that combine multiple strategies that work together to prevent suicide. Take a look at these just-released tools and please share widely with your networks: http://bit.ly/_Communities

Again, we appreciate everyone's assistance and collaboration.
Thank you.

Kim
****

Email Announcement
Subject Line – Just-Released: New Suicide Prevention Tools to Help Guide Communities
Good afternoon,
We are pleased to share two new resources aimed at improving community-based suicide prevention efforts nationwide.
The National Action Alliance for Suicide Prevention (Action Alliance) and its partners including the American Foundation for Suicide Prevention, Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration's Suicide Prevention Resource Center (SPRC)—recently released the following resources:

- **Transforming Communities: Key Elements for Comprehensive Community-Based Suicide Prevention**

Developed by the Action Alliance, this resource presents seven key elements for comprehensive community-based suicide prevention, identified via a review of relevant programs, guidance, and models. The elements are key considerations that should guide community-based suicide prevention efforts—aimed at helping communities create policies, programs, and services that reduce suicide and improve individual, family, and community health. They are meant as broad guidance for the field, and can help inform the development of suicide prevention programs and future resources.

- **Preventing Suicide: A Technical Package of Policy, Programs, and Practices**

Developed by CDC, this resource helps states and communities take advantage of the best available evidence for suicide prevention interventions. The package highlights seven strategies for suicide prevention and the evidence of their impact on suicidal behaviors and related risk and protective factors.
The two resources synthesize current knowledge about community-based suicide prevention and emphasize the need for comprehensive efforts that combine multiple strategies that work together to prevent suicide. The first resource, released by the Action Alliance, identifies seven key elements that should guide program planning and implementation. The second resource, released by CDC, outlines specific, evidence-based suicide prevention strategies for communities to consider as a part of their comprehensive approach. Together, these two resources address *how* communities can carry out suicide prevention efforts and *what* they can do.

Community leaders, suicide prevention program planners, and others can use these new resources to guide the planning, implementation, and evaluation of comprehensive community-based suicide prevention efforts. The resources can also inform the development of future resources, such as step-by-step implementation guides, tools, and websites tailored to the needs of specific communities and settings (e.g., schools, workplaces, justice system).
The strategies and elements outlined in the two resources support the goals and objectives of the *National Strategy for Suicide Prevention* and the Action Alliance'sgoal, in partnership with AFSP, to reduce the annual rate of suicide 20 percent by 2025.

To learn more about these resources and how they can be used, the Action Alliance will be hosting a 90-minute webinar on April 12. To register for the webinar, go to: http://bit.ly/Transforming_Communities and please share widely with your networks.
Additionally, please take a look at the Action Alliance's press release: http://bit.ly/_Communities.
Lastly, we encourage you to please promote the resources by sharing them via your social media channels. Below are a few tailorable posts, for your convenience.
Twitter:

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Thank you for your collaboration and commitment.

# # #

My Best,

Avery
Avery Belyeu
National Partnerships Associate
National Action Alliance for Suicide Prevention
The Education Development Center (EDC)
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
(828) 406-4029 (Direct)

FOR IMMEDIATE RELEASE
April 6, 2017

MEDIA CONTACT:
Kim Torguson - ktorguson@edc.org
(202) 572-3737

Suicide Prevention Tools Launched to Guide Communities Nationwide

National groups release comprehensive guidance aimed at reducing annual suicide rate in the U.S.

Washington, D.C.—New tools to improve community-based suicide prevention efforts were released today by the National Action Alliance for Suicide Prevention (Action Alliance), the nation's public-private partnership championing suicide prevention as a national priority, and its partners from the Centers for Disease Control and Prevention (CDC), American Foundation for Suicide Prevention (AFSP), and the Substance Abuse and Mental Health Services Administration's Suicide Prevention Resource Center (SPRC).

Suicide remains one of the 10 leading causes of death in the U.S., causing tremendous pain and loss to communities across the country—especially rural communities recent CDC data show.

The Action Alliance aims to advance the *National Strategy for Suicide Prevention* (NSSP)—a roadmap that when implemented, will lead to the vision of a nation free from the tragic experience of suicide. According to the *NSSP*, community-based programs, policies, and services *can* play an important role in suicide prevention. To ensure that communities know where to start and what they can do to implement comprehensive suicide prevention efforts, the Action Alliance and several of its national and community partners jointly released two resources that synthesize current knowledge about community-based suicide prevention and emphasize the need for comprehensive efforts that combine multiple strategies that work together to prevent suicide. The strategies and elements outlined in the two resources support the goals and objectives of the *NSSP*.

The first resource, released by the Action Alliance, identifies seven key elements that should guide program planning and implementation. The second resource, released by CDC, outlines specific, evidence-based suicide prevention strategies for communities to consider as a part of their comprehensive approach. Together, these two resources address *how* communities can carry out suicide prevention efforts and *what* they can do.

"These resources are a result of tremendous collaboration among various partners from the public and private sectors coming together to help prevent suicide at the community level," said Dr. Jerry Reed, director of SPRC and executive committee member of the Action Alliance. "The collective efforts by dedicated people and groups within the field of suicide prevention create a robust knowledge base that can help move our work forward while preventing duplication."

These new resources include:

- **Transforming Communities: Key Elements for Comprehensive Community-Based Suicide Prevention**
  Developed by the Action Alliance, this resource presents seven key elements for comprehensive community-based suicide prevention, identified via a review of relevant programs, guidance, and models. The elements are key considerations that should guide community-based suicide prevention efforts—aimed at helping communities create policies, programs, and services that reduce suicide and improve individual, family, and community health. They are meant as broad guidance for the field, and can help inform the development of suicide prevention programs and future resources.

- **Preventing Suicide: A Technical Package of Policy, Programs, and Practices**
  Developed by CDC, this resource helps states and communities take advantage of the best available evidence for suicide prevention interventions. The package highlights seven strategies for suicide prevention and the evidence of their impact on suicidal behaviors and related risk and protective factors.

"We know that suicide is preventable. These resources will help communities to start now, act on the best available evidence, and work together." said James Mercy, Ph.D., director, CDC's Division of Violence Prevention, National Center for Injury Prevention and Control. "The strategies laid out in the technical package, as well as the key elements outlined in the paper, are intended to work in combination and reinforce each other."

Community leaders, suicide prevention program planners, and others can use these new resources to guide the planning, implementation, and evaluation of comprehensive community-based suicide prevention efforts. The resources can also inform the development of future resources, such as step-by-step implementation guides, tools, and websites tailored to the needs of specific communities and settings (e.g., schools, workplaces, justice system).

"We are pleased that AFSP and the Action Alliance have set a common goal to reduce the annual suicide rate 20 percent by 2025," said Bob Gebbia, AFSP's chief executive officer. "Working together to develop and implement comprehensive community-based suicide prevention strategies will help us to achieve this goal—saving and improving the most lives possible."

# # #

ADDITIONAL INFORMATION ABOUT RESOURCES:
On April 12, the Action Alliance will host a 90-minute webinar to provide a detailed overview about the two resources. To register for the webinar, go to: http://bit.ly/Transforming_Communities.

FOR MEDIA PARTNERS:
Research shows that the media may influence suicide rates by the way they report on suicide. Evidence suggests that when the media tell stories of people positively coping in suicidal moments, more suicides can be prevented. We urge all members of the media working on these stories to refer to the Recommendations for Reporting on Suicide for best practices for safely and accurately reporting on suicide. For stories of persons with lived experience of suicidality and finding hope, refer to www.lifelineforattemptsurvivors.org.

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION:

The National Action Alliance for Suicide Prevention is the public-private partnership working to advance the *National Strategy for Suicide Prevention* and make suicide prevention a national priority. The Substance Abuse and Mental Health Services Administration provides funding to EDC to operate and manage the Secretariat for the Action Alliance which was launched in 2010. Learn more at actionallianceforsuicideprevention.org and join the conversation on suicide prevention by following the Action Alliance on Facebook, Twitter, and YouTube.

From: Warner, Margaret (CDC/OPHSS/NCHS)
Sent: 2 Nov 2016 17:02:56 -0400
To: Alexis O'Brien;Belyeu, Avery;'Eileen.Zeller@samhsa.hhs.gov';'Dan Reidenberg';'John Draper';Stout, Elly;'Jack Benson';Stephanie Coggin;eneely@reingold.com;Stone, Deborah (CDC/ONDIEH/NCIPC);Carr, Colleen;'Mark.Weber@hhs.gov';'Amy Kulp';'steve.mendelsohn@thetrevorproject.org';'Frances Gonzalez';'Michael Rosen';'Ashley Vactor';Holland, Kristin (CDC/ONDIEH/NCIPC);Melnyk, Liliya;Crosby, Alexander (CDC/ONDIEH/NCIPC);'michaelle.scanlon@nih.gov';'james.mcelroy@nih.gov';Hedegaard, Holly (CDC/OPHSS/NCHS);'Paul Lauricella';'rebecca.kurikeshu@nih.gov';Sobottka, Linda;Gass, Jesse;Scanlon, Michaelle (NIH/NIMH) [C];Reed, Jerry;Padgett, Jason;Zeller, Eileen (SAMHSA/CMHS);Kurikeshu, Rebecca (NIH/NIMH) [C];Steve Mendelsohn
Cc: Curtin, Sally C. (CDC/OPHSS/NCHS)
Subject: RE: Action Alliance Media Messaging Work Group Call- Potential Data Release Planning Call.

Thanks for sending.
It would be interesting to see a comparison of federal funding to reduce MVTC deaths. Because the comparison is to MV deaths, I did want to point you to an MMWR highlighting the success in reducing MV deaths which is considered one of the great public health achievements of the 20th century. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4818a1.htm . And http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6019a5.htm
Here is some language about how the MV deaths were reduced using a multi-faceted approach – I think the key here is that it is not one thing, but many different
Government agencies and other organizations joined together to achieve great reductions in the number of deaths from motor vehicle crashes (8,9). A comprehensive approach, including improvements in the safety of vehicles; improvements in roadways; increased use of restraint systems, such as seat belts and child safety seats; reductions in speed; and also efforts to reduce driving under the influence of alcohol and drugs, contributed to the decline in motor vehicle related deaths. Using a comprehensive, multifaceted approach, it may be possible to reverse the trend in [suicide] mortality. http://www.cdc.gov/nchs/products/databriefs/db81.htm
Let me know if you have further questions.
Thanks,
Margaret
NCHS

From: Alexis O'Brien [mailto:AOBrien@afsp.org]
Sent: Wednesday, November 02, 2016 4:26 PM
To: Belyeu, Avery ; 'Eileen.Zeller@samhsa.hhs.gov'; 'Dan Reidenberg' ; 'John Draper' ; Stout, Elly ; 'Jack Benson' ; Stephanie Coggin ; eneely@reingold.com; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Carr, Colleen ; 'Mark.Weber@hhs.gov'; 'Amy Kulp' ; 'steve.mendelsohn@thetrevorproject.org'; 'Frances Gonzalez' ; 'Michael Rosen' ; 'Ashley Vactor' ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Melnyk, Liliya ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; 'michaelle.scanlon@nih.gov'; 'james.mcelroy@nih.gov'; Hedegaard, Holly (CDC/OPHSS/NCHS) ; 'Paul Lauricella' ; 'rebecca.kurikeshu@nih.gov'; Sobottka, Linda ; Gass, Jesse ; Scanlon, Michaelle (NIH/NIMH) [C] ; Reed, Jerry ; Padgett, Jason ; Warner, Margaret (CDC/OPHSS/NCHS) ; Zeller, Eileen (SAMHSA/CMHS) ; Kurikeshu, Rebecca (NIH/NIMH) [C] ; Steve Mendelsohn
Subject: RE: Action Alliance Media Messaging Work Group Call- Potential Data Release Planning Call.
Please see attached re: research funding.

From: Belyeu, Avery [mailto:ABelyeu@edc.org]
Sent: Wednesday, November 02, 2016 4:15 PM

To: Belyeu, Avery; 'Eileen.Zeller@samhsa.hhs.gov'; 'Dan Reidenberg'; 'John Draper'; Stout, Elly; 'Jack Benson'; Stephanie Coggin; eneely@reingold.com; Stone, Deborah (CDC/ONDIEH/NCIPC; Carr, Colleen; 'Mark.Weber@hhs.gov'; 'Amy Kulp'; 'steve.mendelsohn@thetrevorproject.org'; 'Frances Gonzalez'; 'Michael Rosen'; 'Ashley Vactor'; Holland, Kristin (CDC/ONDIEH/NCIPC; Melnyk, Liliya; Crosby, Alexander (CDC/ONDIEH/NCIPC; 'michaelle.scanlon@nih.gov'; 'james.mcelroy@nih.gov'; Hedegaard, Holly (CDC/OPHSS/NCHS; 'Paul Lauricella'; 'rebecca.kurikeshu@nih.gov'; Sobottka, Linda; Gass, Jesse; Scanlon, Michaelle (NIH/NIMH) [C; Reed, Jerry; Padgett, Jason; Warner, Margaret (CDC/OPHSS/NCHS;
Cc: Zeller, Eileen (SAMHSA/CMHS; Alexis O'Brien; Kurikeshu, Rebecca (NIH/NIMH) [C; Steve Mendelsohn
Subject: FW: Action Alliance Media Messaging Work Group Call- Potential Data Release Planning Call.
Importance: High

Please see attached.

From: Pearson, Jane L (NIH/NIMH) [E] [mailto:jpearson@mail.nih.gov]
Sent: Wednesday, November 02, 2016 11:59 AM
To: Belyeu, Avery <ABelyeu@edc.org>; 'Eileen.Zeller@samhsa.hhs.gov'; 'Dan Reidenberg' <dreidenberg@save.org>; 'John Draper' <JohnD@mhaofnyc.org>; Stout, Elly <estout@edc.org>; 'Jack Benson' <jbenson@reingold.com>; 'Stephanie Coggin' <SCoggin@afsp.org>; eneely@reingold.com; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Carr, Colleen <ccarr@edc.org>; 'Mark.Weber@hhs.gov'; 'Amy Kulp' <ajkulp@suicidology.org>; 'steve.mendelsohn@thetrevorproject.org'; 'Frances Gonzalez' <fgonzalez@mhaofnyc.org>; 'Michael Rosen' <mrosen@mhaofnyc.org>; 'Ashley Vactor' <AVactor@mhaofnyc.org>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Melnyk, Liliya <LMelnyk@edc.org>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@CDC.GOV>; 'michaelle.scanlon@nih.gov'; 'james.mcelroy@nih.gov'; Hedegaard, Holly (CDC/OPHSS/NCHS) <hdh6@cdc.gov>; 'Paul Lauricella' <plauricella@reingold.com>; 'rebecca.kurikeshu@nih.gov'; Sobottka, Linda <lsobottka@edc.org>; Gass, Jesse <JGass@edc.org>; Scanlon, Michaelle (NIH/NIMH) [C] <michaelle.scanlon@nih.gov>; Reed, Jerry <jreed@edc.org>; Padgett, Jason <JPadgett@edc.org>; Warner, Margaret (CDC/OPHSS/NCHS) <mmw9@CDC.GOV>
Cc: Zeller, Eileen (SAMHSA/CMHS) <Eileen.Zeller@samhsa.hhs.gov>; Alexis O'Brien <AOBrien@afsp.org>; Kurikeshu, Rebecca (NIH/NIMH) [C] <rebecca.kurikeshu@nih.gov>; Steve Mendelsohn <Steve.Mendelsohn@thetrevorproject.org>
Subject: RE: Action Alliance Media Messaging Work Group Call- Potential Data Release Planning Call.
Importance: High

Hi all-

We understand from NCHS that the data brief was done with publicly available data, so NIMH developed the attached document for our own INTERNAL USE to prepare for any press inquiries. It is not intended for distribution, and I am sending in hopes that it facilitates our discussion later today.

Jane

-----Original Appointment-----
From: Belyeu, Avery [mailto:ABelyeu@edc.org]
Sent: Wednesday, November 02, 2016 11:56 AM
To: Pearson, Jane L (NIH/NIMH) [E]; 'Eileen.Zeller@samhsa.hhs.gov'; 'Dan Reidenberg'; 'John Draper'; Stout, Elly; 'Jack Benson'; 'Stephanie Coggin'; eneely@reingold.com; Stone, Deborah (CDC/ONDIEH/NCIPC); Carr, Colleen; 'Mark.Weber@hhs.gov'; 'Amy Kulp'; 'steve.mendelsohn@thetrevorproject.org'; 'Frances Gonzalez'; 'Michael Rosen'; 'Ashley Vactor'; Pearson, Jane L (NIH/NIMH) [E]; Holland, Kristin (CDC/ONDIEH/NCIPC); Melnyk, Liliya; Crosby, Alexander (CDC/ONDIEH/NCIPC); 'michaelle.scanlon@nih.gov'; 'james.mcelroy@nih.gov'; Hedegaard, Holly

(CDC/OPHSS/NCHS); 'Paul Lauricella'; 'rebecca.kurikeshu@nih.gov'; Sobottka, Linda; Gass, Jesse; Scanlon, Michaelle (NIH/NIMH) [C]; Reed, Jerry; Padgett, Jason; Warner, Margaret (CDC/OPHSS/NCHS)
Cc: Zeller, Eileen (SAMHSA/CMHS); Alexis O'Brien; Kurikeshu, Rebecca (NIH/NIMH) [C]; Steve Mendelsohn
Subject: Action Alliance Media Messaging Work Group Call- Potential Data Release Planning Call.
When: Wednesday, November 02, 2016 3:00 PM-4:00 PM (UTC-06:00) Central Time (US & Canada).
Where: (b)(6) No passcode needed

Dear Media Messaging Workgroup,

Please join a call on Wednesday, November 2nd at 4pm ET/3pm CT/2pm MT/ 1pm PT to discuss an upcoming CDC Quickstat data release.

As in previous calls we will use this time to discuss the information we currently have about the data release and outline next steps for a coordinated and collaborative response.

Please access the call by calling (b)(6) (No passcode needed).

My Best,

Avery

<< File: Agenda. Media Messaging Workgroup Call. 11.2.16.pdf >>

From: Carr, Colleen
Sent: 4 Nov 2016 12:41:41 +0000
To: Belyeu, Avery;'Jane Pearson';'Dan Reidenberg';'John Draper';Stout, Elly;'Jack Benson';'Stephanie Coggin';eneely@reingold.com;Stone, Deborah (CDC/ONDIEH/NCIPC);'Amy Kulp';'Frances Gonzalez';'Michael Rosen';'Ashley Vactor';Pearson, Jane L (NIH/NIMH) [E];Holland, Kristin (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Hedegaard, Holly (CDC/OPHSS/NCHS);'Paul Lauricella';Sobottka, Linda;Gass, Jesse;Scanlon, Michaelle (NIH/NIMH) [C];Reed, Jerry;Padgett, Jason;Warner, Margaret (CDC/OPHSS/NCHS)
Cc: Zeller, Eileen (SAMHSA/CMHS);Alexis O'Brien;Kurikeshu, Rebecca (NIH/NIMH) [C];Steve Mendelsohn
Subject: RE: Action Alliance Statement in response to 4 Nov. MMWR release
Attachments: Action Alliance Statement- 4 Nov MMWR QuickStats.pdf, Action Alliance Statement- 4 Nov MMWR QuickStats.docx

Action Alliance Media Messaging Workgroup,

Please see the attached Action Alliance statement in response to the Nov 4 MMWR from CDC. Thank you for all of your ideas and contributions to this document over the last 24 hours.

Our sincere appreciation to Margy and Sally at NCHS for giving us advance notice this was coming out as well as walking us through the data on Wednesday's call. This was a great example of public and private sector collaboration to advance national suicide prevention efforts.

Please use the PDF version for sharing with your networks (e.g., listservs, social media)- the word version is attached in case you need pieces of content for various communication channels. Amy will take the lead on posting to AAS listserv.

Let's collectively use this statement to ensure our prevention messages are aligned and focused on hope, resiliency, and recovery.

Future efforts: As Margy mentioned on Wednesday's call, 2015 mortality data is expected to be released in December and we will plan to re-convene at that time as well as begin to think about proactive messaging as John proposed on the call.

With sincere appreciation,
Colleen

Colleen Carr, MPH
Manager of Policy and Strategic Partnerships
National Action Alliance for Suicide Prevention
EDC
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
ccarr@edc.org

From: Carr, Colleen
Sent: Thursday, November 03, 2016 10:21 PM
Subject: Action Alliance Statement in response to 4 Nov. MMWR release

All,
The MMWR QuickStat is live on CDC's website if you would like to see it. We are putting the finishing touches on the Action Alliance statement and I will send that out to the full group by 9am tomorrow so folks can distribute via their communication channels.

Feel free to contact me with any questions.

Colleen

-----Original Appointment-----
From: Belyeu, Avery
Sent: Monday, October 31, 2016 3:50 PM
To: Belyeu, Avery; 'Jane Pearson'; 'Dan Reidenberg'; 'John Draper'; Stout, Elly; 'Jack Benson'; 'Stephanie Coggin'; eneely@reingold.com; 'Deborah Stone'; Carr, Colleen; 'Amy Kulp'; 'Frances Gonzalez'; 'Michael Rosen'; 'Ashley Vactor'; 'Pearson, Jane L (NIH/NIMH) [E]'; 'Holland, Kristin (CDC/ONDIEH/NCIPC)'; Melnyk, Liliya; 'Crosby, Alexander (CDC/ONDIEH/NCIPC)'; 'Hedegaard, Holly (CDC/OPHSS/NCHS)'; 'Paul Lauricella'; Sobottka, Linda; Gass, Jesse; 'Scanlon, Michaelle (NIH/NIMH) [C]'; Reed, Jerry; Padgett, Jason; Warner, Margaret (CDC/OPHSS/NCHS)
Cc: Zeller, Eileen (SAMHSA/CMHS); Alexis O'Brien; Kurikeshu, Rebecca (NIH/NIMH) [C]; Steve Mendelsohn
Subject: Action Alliance Media Messaging Work Group Call- Potential Data Release Planning Call.
When: Wednesday, November 02, 2016 3:00 PM-4:00 PM (UTC-06:00) Central Time (US & Canada).
Where: (b)(6) No passcode needed

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As in previous calls we will use this time to discuss the information we currently have about the data release and outline next steps for a coordinated and collaborative response.

Please access the call by calling (b)(6) (No passcode needed).

My Best,
Avery

THE NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION RESPONDS TO YOUTH SUICIDE DATA PUBLISHED IN THE *MORBIDITY AND MORTALITY WEEKLY REPORT*.

A statement prepared by The National Action Alliance for Suicide Prevention (Action Alliance)
Contact: Colleen Carr (ccarr@edc.org), National Action Alliance for Suicide Prevention

Washington, D.C. (November 4, 2016)—Data published in the November 4th edition of the Centers for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report (MMWR)* describe death rates for motor vehicle traffic injury, suicide, and homicide among children and adolescents aged 10–14 years old. The data shows suicide death data for 2009 through 2014 increasing for youth ages 10–14 and surpassing motor vehicle deaths in 2014. The number of motor vehicle deaths within this age group has declined dramatically from more than 4 deaths per 100,000 people to less than 2 deaths per 100,000. It is important to note that the data still show that suicide is a relatively rare event, but that additional youth suicide prevention efforts are needed.

These data underscore the need for a robust approach to youth suicide prevention that is similar to the comprehensive approach that effectively decreased motor vehicle traffic fatalities over the last decade.

The significant reduction in motor vehicle fatalities is documented as a "20th Century Public Health Achievement"[i]. This achievement required a comprehensive approach including infrastructure improvements, policy and system change, partnerships, education and awareness[ii]. Efforts included leadership at the national level, significant federal investments—in 2015, the National Highway and Traffic Safety Administration funded over $576m in grants to promote motor vehicle safety and the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) funded approximately $60m in grants for suicide prevention programming[iii,iv]—cross-sector collaboration, citizen and community-based advocacy, and public-private partnerships[v]. If implemented and brought to scale, a similar comprehensive, multifaceted approach, as outlined in the National Strategy for Suicide Prevention, has the potential to reverse the trend in suicide mortality.

Implementation of a comprehensive approach to youth suicide prevention (including, but not limited to identifying youth at risk, building connectedness and resiliency, and connecting youth to evidence-based follow-up care services) has shown promise in reducing youth suicidal behavior. Counties that received a SAMHSA youth suicide prevention grant and implemented youth suicide prevention programming were found to have reduced youth suicide rates and attempt rates when compared to counties without funded youth suicide prevention programming. However, efforts must be maintained to sustain the progress.[vivii] Several National Institutes of Health (NIH)-funded prevention programs aimed at reducing risk factors (e.g., aggression, family conflict) for suicide also reported preventing suicidal thoughts and behaviors for as long as a decade.[viii] This evidence indicates that a comprehensive approach to suicide prevention has the potential to reduce the number of suicide deaths among youth when broadly implemented, scaled up, and sustained.

The Action Alliance encourages widespread awareness and understanding of the youth suicide warning signs as well as resources for youth who are in crisis.

Youth Suicide Warning Signs:
Recently released consensus guidelines identified the following youth suicide warning signs:

- Talking about or making plans for suicide
- Expressing hopelessness about the future
- Displaying severe/overwhelming emotional pain or distress
- Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of the warning signs above[ix]

If a youth is in crisis, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). The National Suicide Prevention Lifeline is free, confidential, and available 24 hours a day.

These data provide a renewed call to action to address suicide in our nation. For every person who dies by suicide, there are 278 who think seriously about suicide annually but do not die[x]. These untold stories of hope and recovery are the stories of suicide prevention, stories that are informing the Action Alliance's efforts to prevent suicide every day.

The Action Alliance is the public-private partnership that collaborates with more than 250 public and private sector organizations to advance the National Strategy for Suicide Prevention. The Action Alliance works diligently with national partners to promote a comprehensive approach to suicide prevention.

Key Youth Suicide Prevention Resources:

- Youth Suicide Warning Signs[xi]- Consensus guidelines on youth suicide warning signs.
- National Suicide Prevention Lifeline - Youth Resources[xii]- Resources for youth, including how to access the National Suicide Prevention Lifeline and other resources for youth in crisis.
- Society for the Prevention of Teen Suicide[xiii]- Resources for youth who may be having suicidal thoughts. You can also find information on how to cope if a friend dies by suicide.
- Suicide Prevention Resource Center- Resources for Parents/Guardians/Families[xiv]- Resources for parents, guardians, and other family members.
- The Trevor Project[xv]- Provides crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth ages 13–24. The Trevor Helpline is a 24-hour toll-free suicide hotline at 1-866-488-7386. TrevorChat is available 7 days a week between 3 p.m. and 9 p.m. ET. Trevor Text is available on Thursdays and Fridays between 4 p.m. and 8 p.m. ET. Text "Trevor" to 202-304-1200.
- Youth Suicide Prevention Program[xvi]- Information for teens about suicide and suicide prevention, depression, how to help, and where to get help.

Media Partners:
Research shows that the media may influence suicide rates by the way they report on suicide. Evidence suggests that when the media tells stories of people positively coping in suicidal moments, more suicides can be prevented. We urge all members of the media working on these stories to refer to the Recommendations for Reporting on Suicide[xvii] for best practices for safely and accurately reporting on suicide. For stories of persons with lived experience of suicidality and finding hope, refer to www.lifelineforattemptsurvivors.org.[xviii]

Other resources for suicide prevention information:

- American Association of Suicidology[xix]
- American Foundation for Suicide Prevention[xx]
- National Suicide Prevention Lifeline[xxi]
- Suicide Awareness and Voices of Education (SAVE)[xxii]
- Suicide Prevention Resource Center[xxiii]
- The Trevor Project[xxiv]

ABOUT THE NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION:
The National Action Alliance for Suicide Prevention is the public-private partnership working to advance the National Strategy for Suicide Prevention and make suicide prevention a national priority. The Substance Abuse and Mental Health Services Administration, through EDC, operates the Secretariat for the Action Alliance, which was launched in 2010 by former U.S. Health and Human Services Secretary Kathleen Sebelius and former U.S. Defense Secretary Robert Gates. For more information, contact Colleen Carr, ccarr@edc.org.

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[i] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4818a1.htm
[ii] http://www.cdc.gov/nchs/products/databriefs/db81.htm
[iii] http://www.nhtsa.gov/About-NHTSA/Highway-Safety-Grant-Programs
[iv] http://www.samhsa.gov/sites/default/files/samhsa-fy-2017-congressional-justification.pdf
[v] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4818a1.htm
[vi] https://www.ncbi.nlm.nih.gov/pubmed/26465226
[vii] http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302496?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&
[viii] http://onlinelibrary.wiley.com/doi/10.1111/sltb.2016.46.issue-S1/issuetoc
[ix] http://www.youthsuicidewarningsigns.org
[x] National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2013). Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/injury/wisqars/index.html. Source for attempts and serious ideation from (combining adult and youth data): CDC YRBS, 2013. Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-42, HHS Publication No. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012. And CDC YRBS, 2013.
[xi] http://www.youthsuicidewarningsigns.org
[xii] http://suicidepreventionlifeline.org/help-yourself/youth/
[xiii] http://www.sptsusa.org/teens/
[xiv] http://www.sprc.org/resources-programs/suicide-prevention-resources-parentsguardiansfamilies
[xv] http://www.thetrevorproject.org
[xvi] http://www.yspp.org/
[xvii] http://reportingonsuicide.org/
[xviii] http://lifelineforattemptsurvivors.org/
[xix] http://www.suicidology.org/
[xx] http://afsp.org/
[xxi] http://www.suicidepreventionlifeline.org/
[xxii] http://www.save.org/
[xxiii] http://www.sprc.org/
[xxiv] http://www.thetrevorproject.org

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Contact: Colleen Carr (ccarr@edc.org), National Action Alliance for Suicide Prevention

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Key Youth Suicide Prevention Resources:

- Youth Suicide Warning Signs[xi]- Consensus guidelines on youth suicide warning signs.
- National Suicide Prevention Lifeline - Youth Resources[xii]- Resources for youth, including how to access the National Suicide Prevention Lifeline and other resources for youth in crisis.
- Society for the Prevention of Teen Suicide[xiii]- Resources for youth who may be having suicidal thoughts. You can also find information on how to cope if a friend dies by suicide.
- Suicide Prevention Resource Center- Resources for Parents/Guardians/Families[xiv]- Resources for parents, guardians, and other family members.
- The Trevor Project[xv]- Provides crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth ages 13–24. The Trevor Helpline is a 24-hour toll-free suicide hotline at 1-866-488-7386. TrevorChat is available 7 days a week between 3 p.m. and 9 p.m. ET. Trevor Text is available on Thursdays and Fridays between 4 p.m. and 8 p.m. ET. Text "Trevor" to 202-304-1200.
- Youth Suicide Prevention Program[xvi]- Information for teens about suicide and suicide prevention, depression, how to help, and where to get help.

Media Partners:
Research shows that the media may influence suicide rates by the way they report on suicide. Evidence suggests that when the media tells stories of people positively coping in suicidal moments, more suicides can be prevented. We urge all members of the media working on these stories to refer to the Recommendations for Reporting on Suicide[xvii] for best practices for safely and accurately reporting on suicide. For stories of persons with lived experience of suicidality and finding hope, refer to www.lifelineforattemptsurvivors.org.[xviii]

Other resources for suicide prevention information:

- American Association of Suicidology[xix]
- American Foundation for Suicide Prevention[xx]
- National Suicide Prevention Lifeline[xxi]
- Suicide Awareness and Voices of Education (SAVE)[xxii]
- Suicide Prevention Resource Center[xxiii]
- The Trevor Project[xxiv]

ABOUT THE NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION:
The National Action Alliance for Suicide Prevention is the public-private partnership working to advance the National Strategy for Suicide Prevention and make suicide prevention a national priority. The Substance Abuse and Mental Health Services Administration, through EDC, operates the Secretariat for the Action Alliance, which was launched in 2010 by former U.S. Health and Human Services Secretary Kathleen Sebelius and former U.S. Defense Secretary Robert Gates. For more information, contact Colleen Carr, ccarr@edc.org.

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[i] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4818a1.htm
[ii] http://www.cdc.gov/nchs/products/databriefs/db81.htm
[iii] http://www.nhtsa.gov/About-NHTSA/Highway-Safety-Grant-Programs
[iv] http://www.samhsa.gov/sites/default/files/samhsa-fy-2017-congressional-justification.pdf
[v] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4818a1.htm
[vi] https://www.ncbi.nlm.nih.gov/pubmed/26465226
[vii] http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302496?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&
[viii] http://onlinelibrary.wiley.com/doi/10.1111/sltb.2016.46.issue-S1/issuetoc
[ix] http://www.youthsuicidewarningsigns.org
[x] National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2013). Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/injury/wisqars/index.html. Source for attempts and serious ideation from (combining adult and youth data): CDC YRBS, 2013. Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-42, HHS Publication No. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012. And CDC YRBS, 2013.
[xi] http://www.youthsuicidewarningsigns.org
[xii] http://suicidepreventionlifeline.org/help-yourself/youth/
[xiii] http://www.sptsusa.org/teens/
[xiv] http://www.sprc.org/resources-programs/suicide-prevention-resources-parentsguardiansfamilies
[xv] http://www.thetrevorproject.org
[xvi] http://www.yspp.org/
[xvii] http://reportingonsuicide.org/
[xviii] http://lifelineforattemptsurvivors.org/
[xix] http://www.suicidology.org/
[xx] http://afsp.org/
[xxi] http://www.suicidepreventionlifeline.org/
[xxii] http://www.save.org/
[xxiii] http://www.sprc.org/
[xxiv] http://www.thetrevorproject.org

From: Zeller, Eileen (SAMHSA/CMHS)
Sent: 4 Nov 2016 13:15:36 +0000
To: Scanlon, Michaelle (NIH/NIMH) [C];John Draper;Carr, Colleen;Belyeu, Avery;Pearson, Jane L (NIH/NIMH) [E];'Dan Reidenberg';Stout, Elly;'Jack Benson';'Stephanie Coggin';eneely@reingold.com;Stone, Deborah (CDC/ONDIEH/NCIPC);'Amy Kulp';Frances Gonzalez;Michael Rosen;Ashley Vactor;Pearson, Jane L (NIH/NIMH) [E];Holland, Kristin (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Hedegaard, Holly (CDC/OPHSS/NCHS);'Paul Lauricella';Sobottka, Linda;Gass, Jesse;Reed, Jerry;Padgett, Jason;Warner, Margaret (CDC/OPHSS/NCHS)
Cc: Alexis O'Brien;Kurikeshu, Rebecca (NIH/NIMH) [C];Steve Mendelsohn
Subject: RE: Action Alliance Statement in response to 4 Nov. MMWR release

Thank you!

From: Scanlon, Michaelle (NIH/NIMH) [C] [mailto:michaelle.scanlon@nih.gov]
Sent: Friday, November 04, 2016 9:07 AM
To: John Draper; Carr, Colleen; Belyeu, Avery; Pearson, Jane L (NIH/NIMH) [E]; 'Dan Reidenberg'; Stout, Elly; 'Jack Benson'; 'Stephanie Coggin'; eneely@reingold.com; Stone, Deborah (CDC/ONDIEH/NCIPC); 'Amy Kulp'; Frances Gonzalez; Michael Rosen; Ashley Vactor; Pearson, Jane L (NIH/NIMH) [E]; Holland, Kristin (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Hedegaard, Holly (CDC/OPHSS/NCHS); 'Paul Lauricella'; Sobottka, Linda; Gass, Jesse; Reed, Jerry; Padgett, Jason; Warner, Margaret (CDC/OPHSS/NCHS)
Cc: Zeller, Eileen (SAMHSA/CMHS); Alexis O'Brien; Kurikeshu, Rebecca (NIH/NIMH) [C]; Steve Mendelsohn
Subject: Re: Action Alliance Statement in response to 4 Nov. MMWR release

Today in the New York Times:
http://www.nytimes.com/2016/11/04/health/suicide-adolescents-traffic-deaths.html?_r=0

From: John Draper <JohnD@mhaofnyc.org>
Date: Friday, November 4, 2016 at 9:02 AM
To: "Carr, Colleen" <ccarr@edc.org>, "Belyeu, Avery" <ABelyeu@edc.org>, Jane Pearson <jpearson@mail.nih.gov>, 'Dan Reidenberg' <dreidenberg@save.org>, "Stout, Elly" <estout@edc.org>, 'Jack Benson' <jbenson@reingold.com>, 'Stephanie Coggin' <SCoggin@afsp.org>, "eneely@reingold.com" <eneely@reingold.com>, "Stone, Deborah (CDC/ONDIEH/NCIPC)" <zaf9@cdc.gov>, 'Amy Kulp' <ajkulp@suicidology.org>, Frances Gonzalez <fgonzalez@mhaofnyc.org>, Michael Rosen <mrosen@mhaofnyc.org>, Ashley Vactor <AVactor@mhaofnyc.org>, Jane Pearson <jpearson@mail.nih.gov>, "Holland, Kristin (CDC/ONDIEH/NCIPC)" <imh1@cdc.gov>, "Crosby, Alexander (CDC/ONDIEH/NCIPC)" <aec1@CDC.GOV>, "Hedegaard, Holly (CDC/OPHSS/NCHS)" <hdh6@cdc.gov>, 'Paul Lauricella' <plauricella@reingold.com>, "Sobottka, Linda" <lsobottka@edc.org>, "Gass, Jesse" <JGass@edc.org>, "Scanlon, Michaelle (NIH/NIMH) [C]" <michaelle.scanlon@nih.gov>, "Reed, Jerry" <jreed@edc.org>, "Padgett, Jason" <JPadgett@edc.org>, "Warner, Margaret (CDC/OPHSS/NCHS)" <mmw9@CDC.GOV>
Cc: "Zeller, Eileen (SAMHSA/CMHS)" <Eileen.Zeller@samhsa.hhs.gov>, Alexis O'Brien <AOBrien@afsp.org>, Rebecca Kurikeshu <rebecca.kurikeshu@nih.gov>, Steve Mendelsohn <Steve.Mendelsohn@thetrevorproject.org>
Subject: Re: Action Alliance Statement in response to 4 Nov. MMWR release

Yes!!
John Draper, Ph.D.

MHA-NYC
Project Director
National Suicide Prevention Lifeline | 1-800-273-TALK (8255)
and
Chief Clinical Officer
MHA-NYC
T: (212) 614-6309
T: (212) 614-6357
suicidepreventionlifeline.org | nfllifeline.org | Twitter | Facebook
The Lifeline is operated by
The Mental Health Association of New York City (**MHA-NYC**)
September is National Suicide Prevention Month.
Become part of the movement at: bethe1to.com.

From: Colleen Carr <ccarr@edc.org>
Date: Friday, November 4, 2016 at 8:58 AM
To: "Belyeu, Avery" <ABelyeu@edc.org>, 'Jane Pearson' <jpearson@nih.gov>, PsyD Daniel Reidenberg <dreidenberg@save.org>, John Draper <JohnD@mhaofnyc.org>, Elly Stout <estout@edc.org>, Jack Benson <jbenson@reingold.com>, Stephanie Coggin <SCoggin@afsp.org>, Elizabeth Neely <eneely@reingold.com>, Deborah Stone <zaf9@cdc.gov>, "ajkulp@suicidology.org" <ajkulp@suicidology.org>, Frances Gonzalez <fgonzalez@mhaofnyc.org>, Michael Rosen <mrosen@mhaofnyc.org>, Ashley Vactor <AVactor@mhaofnyc.org>, "jpearson@mail.nih.gov" <jpearson@mail.nih.gov>, "'Holland, Kristin (CDC/ONDIEH/NCIPC)'" <imh1@cdc.gov>, Alexander Crosby <aec1@cdc.gov>, "'Hedegaard, Holly (CDC/OPHSS/NCHS)'" <hdh6@cdc.gov>, 'Paul Lauricella' <plauricella@reingold.com>, "Sobottka, Linda" <lsobottka@edc.org>, "Gass, Jesse" <JGass@edc.org>, "'Scanlon, Michaelle (NIH/NIMH) [C]'" <michaelle.scanlon@nih.gov>, Jerry Reed <jreed@edc.org>, Jason Padgett <JPadgett@edc.org>, "Warner, Margaret (CDC/OPHSS/NCHS)" <mmw9@cdc.gov>
Cc: Eileen Zeller <Eileen.Zeller@samhsa.hhs.gov>, Alexis O'Brien <AOBrien@afsp.org>, "Kurikeshu, Rebecca (NIH/NIMH) [C]" <rebecca.kurikeshu@nih.gov>, Steve Mendelsohn <Steve.Mendelsohn@thetrevorproject.org>
Subject: RE: Action Alliance Statement in response to 4 Nov. MMWR release

In response to a great question I just received- For organizations that will use this content to inform an organization-specific press release, please be sure to include a reference to the Action Alliance to spread the message of the importance of public and private sector collaboration to reduce the burden of suicide.

For example: _(enter organization name)__ is a partner of the National Action Alliance for Suicide Prevention, the public-private partnership advancing the National Strategy for Suicide Prevention and championing suicide prevention as a national priority.

-----Original Message-----
From: Carr, Colleen
Sent: Friday, November 04, 2016 8:42 AM
To: Belyeu, Avery <ABelyeu@edc.org>; 'Jane Pearson' <jpearson@nih.gov>; 'Dan Reidenberg' <dreidenberg@save.org>; 'John Draper' <JohnD@mhaofnyc.org>; Stout, Elly <estout@edc.org>; 'Jack Benson' <jbenson@reingold.com>; 'Stephanie Coggin' <SCoggin@afsp.org>; 'eneely@reingold.com' <eneely@reingold.com>; 'Deborah Stone' <zaf9@cdc.gov>; 'Amy Kulp' <ajkulp@suicidology.org>;

'Frances Gonzalez' <fgonzalez@mhaofnyc.org>; 'Michael Rosen' <mrosen@mhaofnyc.org>; 'Ashley Vactor' <AVactor@mhaofnyc.org>; 'Pearson, Jane L (NIH/NIMH) [E]' <jpearson@mail.nih.gov>; 'Holland, Kristin (CDC/ONDIEH/NCIPC)' <imh1@cdc.gov>; 'Crosby, Alexander (CDC/ONDIEH/NCIPC)' <aec1@cdc.gov>; 'Hedegaard, Holly (CDC/OPHSS/NCHS)' <hdh6@cdc.gov>; 'Paul Lauricella' <plauricella@reingold.com>; Sobottka, Linda <lsobottka@edc.org>; Gass, Jesse <JGass@edc.org>; 'Scanlon, Michaelle (NIH/NIMH) [C]' <michaelle.scanlon@nih.gov>; Reed, Jerry <jreed@edc.org>; Padgett, Jason <JPadgett@edc.org>; 'Warner, Margaret (CDC/OPHSS/NCHS)' <mmw9@cdc.gov>
Cc: 'Zeller, Eileen (SAMHSA/CMHS)' <Eileen.Zeller@samhsa.hhs.gov>; 'Alexis O'Brien' <AOBrien@afsp.org>; 'Kurikeshu, Rebecca (NIH/NIMH) [C]' <rebecca.kurikeshu@nih.gov>; 'Steve Mendelsohn' <Steve.Mendelsohn@thetrevorproject.org>
Subject: RE: Action Alliance Statement in response to 4 Nov. MMWR release

Action Alliance Media Messaging Workgroup,

Please see the attached Action Alliance statement in response to the Nov 4 MMWR from CDC. Thank you for all of your ideas and contributions to this document over the last 24 hours.

Our sincere appreciation to Margy and Sally at NCHS for giving us advance notice this was coming out as well as walking us through the data on Wednesday's call. This was a great example of public and private sector collaboration to advance national suicide prevention efforts.

Please use the PDF version for sharing with your networks (e.g., listservs, social media)- the word version is attached in case you need pieces of content for various communication channels. Amy will take the lead on posting to AAS listserv.

Let's collectively use this statement to ensure our prevention messages are aligned and focused on hope, resiliency, and recovery.

Future efforts: As Margy mentioned on Wednesday's call, 2015 mortality data is expected to be released in December and we will plan to re-convene at that time as well as begin to think about proactive messaging as John proposed on the call.

With sincere appreciation,

Colleen

Colleen Carr, MPH
Manager of Policy and Strategic Partnerships National Action Alliance for Suicide Prevention EDC
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
ccarr@edc.org

From: Carr, Colleen
Sent: Thursday, November 03, 2016 10:21 PM
Subject: Action Alliance Statement in response to 4 Nov. MMWR release

All,

The MMWR QuickStat is live on CDC's website if you would like to see it. We are putting the finishing touches on the Action Alliance statement and I will send that out to the full group by 9am tomorrow so folks can distribute via their communication channels.

Feel free to contact me with any questions.

Colleen

-----Original Appointment-----
From: Belyeu, Avery
Sent: Monday, October 31, 2016 3:50 PM
To: Belyeu, Avery; 'Jane Pearson'; 'Dan Reidenberg'; 'John Draper'; Stout, Elly; 'Jack Benson'; 'Stephanie Coggin'; eneely@reingold.com; 'Deborah Stone'; Carr, Colleen; 'Amy Kulp'; 'Frances Gonzalez'; 'Michael Rosen'; 'Ashley Vactor'; 'Pearson, Jane L (NIH/NIMH) [E]'; 'Holland, Kristin (CDC/ONDIEH/NCIPC)';

Melnyk, Liliya; 'Crosby, Alexander (CDC/ONDIEH/NCIPC)'; 'Hedegaard, Holly (CDC/OPHSS/NCHS)'; 'Paul Lauricella'; Sobottka, Linda; Gass, Jesse; 'Scanlon, Michaelle (NIH/NIMH) [C]'; Reed, Jerry; Padgett, Jason; Warner, Margaret (CDC/OPHSS/NCHS)
Cc: Zeller, Eileen (SAMHSA/CMHS); Alexis O'Brien; Kurikeshu, Rebecca (NIH/NIMH) [C]; Steve Mendelsohn
Subject: Action Alliance Media Messaging Work Group Call- Potential Data Release Planning Call.
When: Wednesday, November 02, 2016 3:00 PM-4:00 PM (UTC-06:00) Central Time (US & Canada).
Where: (b)(6) No passcode needed
Dear Media Messaging Workgroup,
Please join a call on Wednesday, November 2nd at 4pm ET/3pm CT/2pm MT/ 1pm PT to discuss an upcoming CDC Quickstat data release.
<< File: Agenda. Media Messaging Workgroup Call. 11.2.16.pdf >>
As in previous calls we will use this time to discuss the information we currently have about the data release and outline next steps for a coordinated and collaborative response.
Please access the call by calling (b)(6) (No passcode needed).
My Best,
Avery

From: Scanlon, Michaelle (NIH/NIMH) [C]
Sent: 4 Nov 2016 15:14:26 +0000
To: Belyeu, Avery;Carr, Colleen;Pearson, Jane L (NIH/NIMH) [E];'Dan Reidenberg';'John Draper';Stout, Elly;'Jack Benson';'Stephanie Coggin';eneely@reingold.com;Stone, Deborah (CDC/ONDIEH/NCIPC);'Amy Kulp';'Frances Gonzalez';'Michael Rosen';'Ashley Vactor';Pearson, Jane L (NIH/NIMH) [E];Holland, Kristin (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Hedegaard, Holly (CDC/OPHSS/NCHS);'Paul Lauricella';Sobottka, Linda;Gass, Jesse;Reed, Jerry;Padgett, Jason;Warner, Margaret (CDC/OPHSS/NCHS)
Cc: Zeller, Eileen (SAMHSA/CMHS);Alexis O'Brien;Kurikeshu, Rebecca (NIH/NIMH) [C];Steve Mendelsohn
Subject: Re: Action Alliance Statement in response to 4 Nov. MMWR release

CNN also picked up the story. You can find it here:

http://www.cnn.com/2016/11/03/health/kids-suicide-deaths-increase/index.html

On 11/4/16, 10:55 AM, "Belyeu, Avery" <ABelyeu@edc.org> wrote:

Hello All,

This statement has also been posted on the Action Alliance website and may be accessed at the link below:

http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Action%20Alliance%20Statement-%204%20Nov%20MMWR%20QuickStats.pdf

Please feel free to use this link or the shorter link below when posting to Facebook and twitter.
https://goo.gl/trsKg5

My Best,
Avery

-----Original Message-----
From: Carr, Colleen
Sent: Friday, November 04, 2016 7:42 AM
To: Belyeu, Avery <ABelyeu@edc.org>; 'Jane Pearson' <jpearson@nih.gov>; 'Dan Reidenberg' <dreidenberg@save.org>; 'John Draper' <JohnD@mhaofnyc.org>; Stout, Elly <estout@edc.org>; 'Jack Benson' <jbenson@reingold.com>; 'Stephanie Coggin' <SCoggin@afsp.org>; eneely@reingold.com; 'Deborah Stone' <zaf9@cdc.gov>; 'Amy Kulp' <ajkulp@suicidology.org>; 'Frances Gonzalez' <fgonzalez@mhaofnyc.org>; 'Michael Rosen' <mrosen@mhaofnyc.org>; 'Ashley Vactor' <AVactor@mhaofnyc.org>; 'Pearson, Jane L (NIH/NIMH) [E]' <jpearson@mail.nih.gov>; 'Holland, Kristin (CDC/ONDIEH/NCIPC)' <imh1@cdc.gov>; 'Crosby, Alexander (CDC/ONDIEH/NCIPC)' <aec1@cdc.gov>; 'Hedegaard, Holly (CDC/OPHSS/NCHS)' <hdh6@cdc.gov>; 'Paul Lauricella' <plauricella@reingold.com>; Sobottka, Linda <lsobottka@edc.org>; Gass, Jesse <JGass@edc.org>; 'Scanlon, Michaelle (NIH/NIMH) [C]' <michaelle.scanlon@nih.gov>; Reed, Jerry <jreed@edc.org>; Padgett, Jason <JPadgett@edc.org>; Warner, Margaret (CDC/OPHSS/NCHS) <mmw9@cdc.gov>
Cc: Zeller, Eileen (SAMHSA/CMHS) <Eileen.Zeller@samhsa.hhs.gov>; Alexis O'Brien <AOBrien@afsp.org>; Kurikeshu, Rebecca (NIH/NIMH) [C] <rebecca.kurikeshu@nih.gov>; Steve Mendelsohn <Steve.Mendelsohn@thetrevorproject.org>
Subject: RE: Action Alliance Statement in response to 4 Nov. MMWR release

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Future efforts: As Margy mentioned on Wednesday's call, 2015 mortality data is expected to be released in December and we will plan to re-convene at that time as well as begin to think about proactive messaging as John proposed on the call.

With sincere appreciation,
Colleen

Colleen Carr, MPH
Manager of Policy and Strategic Partnerships National Action Alliance for Suicide Prevention EDC
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
ccarr@edc.org

From: Carr, Colleen
Sent: Thursday, November 03, 2016 10:21 PM
Subject: Action Alliance Statement in response to 4 Nov. MMWR release

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Colleen

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From: Belyeu, Avery
Sent: Monday, October 31, 2016 3:50 PM
To: Belyeu, Avery; 'Jane Pearson'; 'Dan Reidenberg'; 'John Draper'; Stout, Elly; 'Jack Benson'; 'Stephanie Coggin'; eneely@reingold.com; 'Deborah Stone'; Carr, Colleen; 'Amy Kulp'; 'Frances Gonzalez'; 'Michael Rosen'; 'Ashley Vactor'; 'Pearson, Jane L (NIH/NIMH) [E]'; 'Holland, Kristin (CDC/ONDIEH/NCIPC)'; Melnyk, Liliya; 'Crosby, Alexander (CDC/ONDIEH/NCIPC)'; 'Hedegaard, Holly (CDC/OPHSS/NCHS)'; 'Paul Lauricella'; Sobottka, Linda; Gass, Jesse; 'Scanlon, Michaelle (NIH/NIMH) [C]'; Reed, Jerry; Padgett, Jason; Warner, Margaret (CDC/OPHSS/NCHS)
Cc: Zeller, Eileen (SAMHSA/CMHS); Alexis O'Brien; Kurikeshu, Rebecca (NIH/NIMH) [C]; Steve

Mendelsohn

Subject: Action Alliance Media Messaging Work Group Call- Potential Data Release Planning Call.
When: Wednesday, November 02, 2016 3:00 PM-4:00 PM (UTC-06:00) Central Time (US & Canada).
Where: (b)(6) No passcode needed

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As in previous calls we will use this time to discuss the information we currently have about the data release and outline next steps for a coordinated and collaborative response.

Please access the call by calling (b)(6) (No passcode needed).

My Best,
Avery

From: Belyeu, Avery
Sent: 20 Mar 2017 14:55:33 +0000
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Elaine Demello;Caraballo, Rachel;Mercy, James (CDC/ONDIEH/NCIPC);Robert Gebbia;Reed, Jerry;Magdala Labre;CMoutier@afsp.org;Stout, Elly;Bird, Doreen;heidi@heidibryan.com;jarrod.hindman@state.co.us;mruhe@naccho.org;Annmarie_white@urmc.rochester.edu;Zeller, Eileen (SAMHSA/CMHS);Dr. John Harrison;Heather.Stokes@livingworks.net;gigi@gcolombini.com;Carr, Colleen;Ken Norton;bprice@cadca.org;Melissa Helm;Torguson, Kimberly
Subject: RE: Action Alliance Update: Transforming Communities Paper

Hello All,

It looks like there will be a lot of great conversations on this topic at AAS. Please note there will also be a full day pre-conference on this topic for state suicide prevention coordinators titled: *State Suicide Prevention Coordinator Preconference – Creating and Supporting Comprehensive Community-based Suicide Prevention Programs*. Presenters include: Adam Swanson ,Patricia Smith, Alan Holmlund, Richard McKeon, Eileen Zeller, Elly Stout, and Avery Belyeu.
We will use the key elements outlined in the Transforming Communities paper as a foundation for this conversation.
My Best,
Avery

From: Stone, Deborah (CDC/ONDIEH/NCIPC) [mailto:zaf9@cdc.gov]
Sent: Monday, March 20, 2017 9:38 AM
To: Elaine Demello ; Belyeu, Avery ; Caraballo, Rachel ; Mercy, James (CDC/ONDIEH/NCIPC) ; Robert Gebbia ; Reed, Jerry ; Magdala Labre ; CMoutier@afsp.org; Stout, Elly ; Bird, Doreen ; heidi@heidibryan.com; jarrod.hindman@state.co.us; mruhe@naccho.org; Annmarie_white@urmc.rochester.edu; Zeller, Eileen (SAMHSA/CMHS) ; Dr. John Harrison ; Heather.Stokes@livingworks.net; gigi@gcolombini.com; Carr, Colleen ; Ken Norton ; bprice@cadca.org; Melissa Helm ; Torguson, Kimberly
Subject: RE: Action Alliance Update: Transforming Communities Paper

Hi Elaine,
Thanks for letting the group know of your AAS presentation. On a related note, I will be presenting on our CDC technical package on Friday 4/28 at 1:30 (Suite 318).
Deb

From: Elaine Demello [mailto:edemello@naminh.org]
Sent: Monday, March 20, 2017 10:16 AM
To: Belyeu, Avery <ABelyeu@edc.org>; Caraballo, Rachel <rcaraballo@edc.org>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Robert Gebbia <RGebbia@afsp.org>; Reed, Jerry <jreed@edc.org>; Magdala Labre (b)(6) Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; CMoutier@afsp.org; Stout, Elly <estout@edc.org>; Bird, Doreen <DBird@edc.org>; heidi@heidibryan.com; jarrod.hindman@state.co.us; mruhe@naccho.org; Annmarie_white@urmc.rochester.edu; Zeller, Eileen (SAMHSA/CMHS) <Eileen.Zeller@samhsa.hhs.gov>; Dr. John Harrison <jharrison@cadca.org>; Heather.Stokes@livingworks.net; gigi@gcolombini.com; Carr, Colleen <ccarr@edc.org>; Ken Norton <knorton@naminh.org>; bprice@cadca.org; Melissa Helm <MHelm@afsp.org>; Torguson, Kimberly

<KTorguson@edc.org>
Subject: RE: Action Alliance Update: Transforming Communities Paper

Congratulations on this work, everyone! I think it has been a timely and comprehensive synthesis of national and international efforts around community implementation.

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Sent: Tuesday, March 14, 2017 5:36 PM
To: Caraballo, Rachel; jam2@cdc.gov; Robert Gebbia; Reed, Jerry; Magdala Labre; zaf9@cdc.gov; CMoutier@afsp.org; Stout, Elly; Bird, Doreen; heidi@heidibryan.com; Elaine Demello; jarrod.hindman@state.co.us; mruhe@naccho.org; Annmarie_white@urmc.rochester.edu; Eileen.Zeller@samhsa.hhs.gov; Dr. John Harrison; Heather.Stokes@livingworks.net; gigi@gcolombini.com; Carr, Colleen; Ken Norton; bprice@cadca.org; Melissa Helm; Torguson, Kimberly
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National Action Alliance for Suicide Prevention

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Elly and All,
This is a wonderful kickoff to have the state SP coordinators briefed on the concepts in the paper! Nice work and good luck- I'm sure the pre-conference session will be great.
Christine

Christine Moutier, MD
Chief Medical Officer
American Foundation for Suicide Prevention
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T: 212-363-3500 x2017
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From: Belyeu, Avery [mailto:ABelyeu@edc.org]
Sent: Tuesday, March 14, 2017 5:36 PM
To: Caraballo, Rachel; jam2@cdc.gov; Robert Gebbia; Reed, Jerry; Magdala Labre; zaf9@cdc.gov; CMoutier@afsp.org; Stout, Elly; Bird, Doreen; heidi@heidibryan.com; Elaine Demello; jarrod.hindman@state.co.us; mruhe@naccho.org; Annmarie_white@urmc.rochester.edu; Eileen.Zeller@samhsa.hhs.gov; Dr. John Harrison; Heather.Stokes@livingworks.net; gigi@gcolombini.com; Carr, Colleen; Ken Norton; bprice@cadca.org; Melissa Helm; Torguson, Kimberly
Subject: Action Alliance Update: Transforming Communities Paper

Dear Working Group,

Thank you all for your feedback to the most recent version of the Transforming Communities paper. Your contributions were all very helpful and will result in an even stronger product.

Please note that the meeting this Friday, March 17th will be cancelled. In lieu of a meeting we would like to provide you with a few key updates:

- The paper is currently being finalized which includes copy editing and graphic design work. We are on track for a late March release.
- Communication leads from SPRC, the Action Alliance, AFSP, SAMHSA and CDC are working together to align our messages regarding this paper and the CDC Technical Package. As part of this process the Action Alliance is creating a communications guide that may be used by partner organizations when the Transforming Communities paper is released. We will share that with you prior to the release date so that you can participate in this unified message.

- We will convene a full group meeting in late April or early May to discuss how to maximize our collective impact on this topic.

Thank you for your ongoing collaboration. If you have any questions regarding the updates listed above please don't hesitate to reach out.

My Best,

Avery

Avery Belyeu
National Partnerships Associate
National Action Alliance for Suicide Prevention
The Education Development Center (EDC)
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
(828) 406-4029 (Direct)



From: Belyeu, Avery
Sent: 15 Dec 2016 15:27:38 +0000
To: Caraballo, Rachel;Carr, Colleen;Mercy, James (CDC/ONDIEH/NCIPC);Reed, Jerry;Robert Gebbia;Magdala Labre;Stone, Deborah (CDC/ONDIEH/NCIPC);CMoutier@afsp.org;Stout, Elly;Melissa Helm
Subject: RE: Action Alliance: CBSP Meeting Agenda
Attachments: White Paper. Potential Reviewers.docx

Please see the list of reviewers attached to this email.

From: Belyeu, Avery
Sent: Thursday, December 15, 2016 9:27 AM
To: Caraballo, Rachel ; Carr, Colleen ; jam2@cdc.gov; Reed, Jerry ; Robert Gebbia ; Magdala Labre ; zaf9@cdc.gov; CMoutier@afsp.org; Stout, Elly ; Melissa Helm
Subject: Action Alliance: CBSP Meeting Agenda

Hello All,

I look forward to speaking with you all tomorrow at 2pm ET/1pm CT/ 12pm MT/ 11am PT as part of the All-Group Call.

Attached to this email is the proposed agenda for that call along with a list of the potential reviewers that have been submitted up to this point.

Per our conversations last week the bulk of this call will be used to invite participants to share thoughts about the review process, identify gaps in our current list, and discuss a coordinated communications plan for the release of the White Paper and the CDC Technical Package.

If you have any thoughts about this agenda please don't hesitate to reach out. I will send this out to the entire group later today.

Thank you for your ongoing commitment to this important work.

My Best,

Avery
Avery Belyeu
National Partnerships Associate
National Action Alliance for Suicide Prevention
The Education Development Center (EDC)
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
(828) 406-4029 (Direct)



CBSP White Paper

Potential External Reviewers

Dr. Trena Anastasia trena@qdgconsulting.com

Ms. Emily Blair Eblair@nami.org

Mary Forsythe-Taber mft@mih4u.org, Makin It Happen, Regional Public Health Coalition, NH

James Gallanos james.gallanos@alaska.gov, State of Alaska

Deb Geobert GoebertD@dop.hawaii.edu , University of Hawai'i

Dr. Julie Goldstein Grumet jgoldstein@edc.org

Dr. Brian Hepburn brian.hepburn@nasmhpd.org

Effie Malley, Consultant, NH (b)(6)

Dr. Richard McKeon Richard.McKeon@samhsa.hhs.gov

Donna Noonan, Oregon donna.noonan@state.or.us

Dr. Dan Reidenberg dreidenberg@save.org

Dr. Alex Ross aross@hrsa.gov

Calondra Tibbs ctibbs@naccho.org

Ms. Kim Walton kwalton@ecommunity.com

From: Padgett, Jason
Sent: 18 Oct 2016 17:23:41 +0000
To: Reed, Jerry;Stout, Elly;Mercy, James (CDC/ONDIEH/NCIPC);Robert Gebbia (b)(6) Stone, Deborah (CDC/ONDIEH/NCIPC);cmoutier@afsp.org
Cc: Rachel Caraballo
Subject: RE: Action Alliance: CBSP section of tomorrow's EXCOM agenda
Attachments: EXCOM-slides-CBSP-section.pdf, Transforming Communities.docx

Good afternoon all,
BLUF: Jerry will facilitate CBSP section of EXCOM meeting tomorrow. Bob & Jim be prepared to speak to work of your subgroups at EXCOM meeting. Jim be prepared to speak to Technical Package, then later alignment as shared on last call. Presentation will be from your seats
Details: I've attached 2 items.
First is the PDF of slides/comments for tomorrow's EXCOM meeting. Please review to understand how the CBSP section of tomorrow's agenda will be facilitated. Bob & Jim, you are welcome to add points of your own as you speak – note red text areas for where you'll be asked by Jerry to elaborate. I, or a team member will specifically give each printed copies tomorrow as well.
Second is the listing that will be in folders of items reviewed.
Safe travels.
Kindly,
-Jason

Jason H. Padgett, MPA, MSM
Center Operations Director, Center for the Study and Prevention of Injury, Violence and Suicide
Secretariat,National Action Alliance for Suicide Prevention
EDC, Inc.
jpadgett@edc.org | Phone: 202-599-0532 | Skype: jason-sprc

***Envisioning A Nation Free From the Tragic Experience of Suicide ***

-----Original Appointment-----
From: Padgett, Jason
Sent: Thursday, April 28, 2016 3:26 PM
To: Padgett, Jason; Reed, Jerry; Stout, Elly; Belyeu, Avery; Mercy, James (CDC/ONDIEH/NCIPC; Robert Gebbia; (b)(6) Deborah Stone; cmoutier@afsp.org; Melnyk, Liliya
Cc: Rachel Caraballo; Jane Pearson
Subject: Action Alliance: Community-based Suicide Prevention Priority Leadership Team Mtg (2pm Eastern/1pm Central/11am Pacific)
When: Friday, October 14, 2016 1:00 PM-2:00 PM (UTC-06:00) Central Time (US & Canada).
Where: Web-based video conference call (see details far below)
-- Do not delete or change any of the following text. --
Join me now in my Personal Room.
JOIN WEBEX MEETING
https://edc1.webex.com/join/jpadgett | (b)(6)
JOIN BY PHONE
1. Call one of the following numbers:

1-617-618-2000 : Audio and Web Conferencing
2. Follow the instructions that you hear on the phone:
Cisco Unified MeetingPlace meeting ID: (b)(6)
Access code: (b)(6)
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Transforming Communities *(Bob Gebbia, Jim Mercy, and Jerry Reed) FROM SEATS*

Overview: The facilitator (TBD) will ask EXCOM-members to briefly (2-3 min) note their work related to community-based suicide prevention since the last EXCOM meeting:

~~Mr. Mark Jones (Union Pacific Corporation) will note the recent Union Pacific-sponsored Rail Industry Summit on Suicide Prevention.~~

~~Dr. Jim Mercy (CDC) will note the pending release of the CDC's "technical package" on suicide prevention.~~

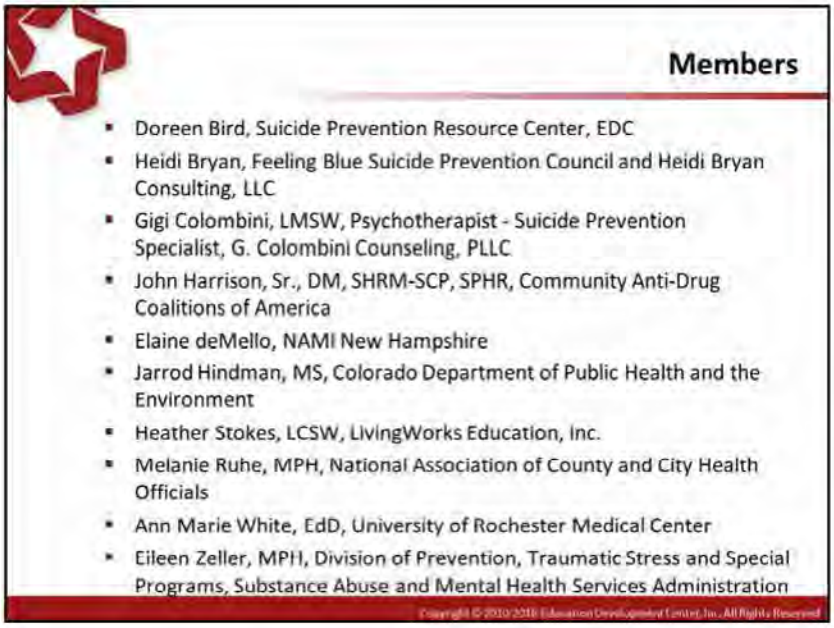
As some point ask Ms. Kana Enomoto (SAMHSA) to note recent SAMHSA-supported community-based suicide prevention efforts via the Action Alliance National Strategy Implementation Assessment Report (if through clearance) and grantee programs, or other SAMHSA advances in suicide prevention.

The Transforming Communities co-leads will then report on progress since our discussion in February for the Action Alliance to determine its role in advancing comprehensive, integrated community-based suicide prevention. The priority group has been working on identifying key elements. Although the process is not yet complete, this presentation to the EXCOM will highlight the potential key elements and discuss potential next steps (including fundable projects) for the Action Alliance to consider.

Potential co-chair talking points during discussion:

Dr. Carolyn Clancy:

I want to start by thanking Jim, Bob, and Jerry for their leadership on this



Jerry (FROM SEAT)

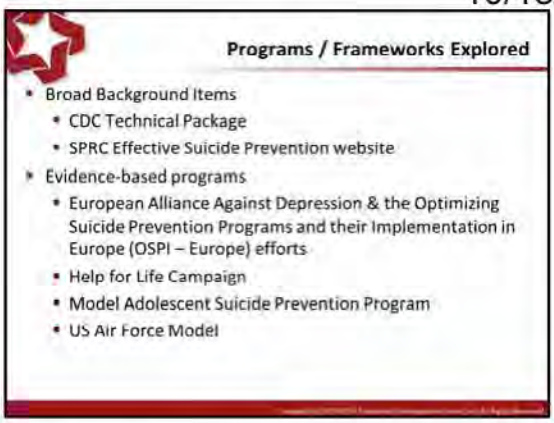
During our last meeting Bob, Jim, and I were charged with the request to explore the possibility of Transforming Communities as a priority of the Action Alliance. Most specifically we were asked to determine an Action Alliance role.

We developed a work plan to explore the key elements of comprehensive integrated community based suicide prevention and engaged the members you see up on the screen.

We basically set about doing the work of a basic environmental scan.

CLICK TO NEXT SLIDE

The co-leads and our support teams met each month in advance of a monthly full group meeting.



Jerry, Jim, & Bob G from seats

Jerry (continuing from last slide) …. We held our first full group meeting and discussed basics about the work and noted that we were at the stage of exploring key elements for programs vs. developing a toolkit for how to … while recognizing the ultimate needs of communities may very well be "how to" guidance. We also had a presentation on the content regarding "Effective Suicide Prevention" repackaged on the recently redesigned SPRC website.

Jerry ask **Jim** to share a little about the CDC technical package.

Jerry continue then to share … We divided the members into 3 groups to explore (1) evidence based program, led by Bob; (2) suicide prevention focused models and frameworks, led by Jerry; and non-suicide prevention focused models and frameworks, led by Jim,

On the screen you see the evidence-based programs – **Bob,** might you share a little about what your group discussed?

BOB – be sure to note you did not review additional NREPP programs as they were not community models (may need to explain what NREPP is). Share additional thoughts.

Thank Bob, then CLICK to next slide …



Jerry, continue to share what your group found in reviewing the suicide focused programs, models, and frameworks.

Then ask **Jim** to do the same for non-suicide focused models/guidance.

Then transition to effort to take the key elements of this and delineate those which seem important to community-based suicide prevention (CLICK to next slide).



Jerry – continued … After the groups explore, we held a face to face meeting, to include additional community, state, and healthcare network representation to discuss the finding of these groups and developed a list of draft elements within a draft white paper. Based on their inputs and further discussion, these are the current STILL DRAFT elements. We continue to work on this as we want to think about best timing and utility of the white paper.

Unity—Broad-based support for a shared vision

Planning—Strategic planning guides implementation

Integration—Multiple integrated suicide prevention strategies

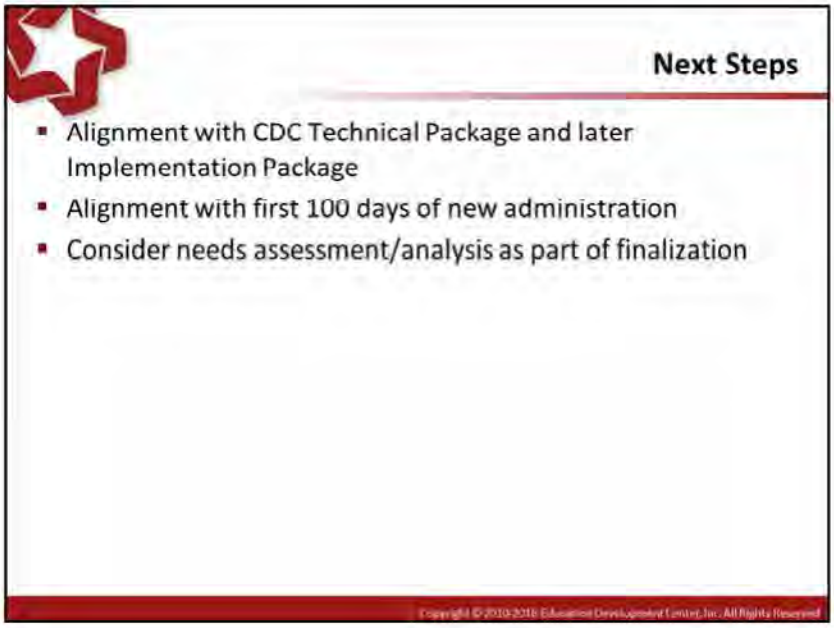
Fit—Alignment with context and culture

Communication—Clear, open, and consistent communication

Data—Surveillance and evaluation data guide action

Sustainability—A focus on long-lasting change

Refer back to **Jim's** sharing of the Technical package (click to next slide)…



Jerry - Ask **Jim** to share about his thoughts about alignment with technical package..

Jerry note need for further review of draft with persons in the field (e.g. AFSP chapter leaders; state SP leads – specifically seeking them to ID a few community SP leaders) to truly get a sense of what is needed at the community level (e.g. is a toolkit; other more specialized technical assistance; etc.)

Ask **Bob / Jim** for additional comments. Then turn to EXCOM for questions /

discussion. CLICK to next slide.


DISCUSSION
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Transforming Communities: Community-based Suicide Prevention

Reviewed programs, models, and guidance

Comprehensive Community-based Suicide Prevention Programs	
Comprehensive Community-based Suicide Prevention Programs	Model Adolescent Suicide Prevention Program U.S. Air Force Suicide Prevention Program Help for Life Program, Québec, Canada European Alliance Against Depression Optimizing Suicide Prevention Programs and their Implementation in Europe Lifespan Program, New South Wales, Australia
Other Suicide Prevention Frameworks, Models, and Guidance	
Suicide Prevention Guidance and Frameworks	SPRC Effective Suicide Prevention Framework CDC Technical Package on Suicide Prevention (in progress) Guidance from IIMHL Match Meeting on Community Suicide Prevention Guidance from NICE, United Kingdom (in progress) Guidance from World Health Organization
Suicide Prevention Systematic Reviews and Individual Evaluations	Systematic reviews of suicide prevention interventions: Mann et al., 2005;[3] Zalsman et al., 2016[4] Evaluations of Garrett Lee Smith Suicide Prevention Program: Walrath et al., 2015;[5] Garraza et al., 2015[6] Suicide prevention interventions in SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)
Planning Models Used in Suicide Prevention	LivingWorks Suicide-Safer Communities Model CONNECT Community Suicide Prevention Model SAMHSA Strategic Prevention Framework (SPF) Communities That Care (University of Washington) Getting to Outcomes® (RAND Corporation and University of South Carolina) State Suicide Prevention Toolkits
Other Information	
Community Health Improvement Models	Collective Impact Model (FSG) County Health Rankings and Roadmaps Action Cycle (RWJ Foundation) Community Health improvement Navigator (CDC)
Other Resources	Community Tool Box (University of Kansas) Coalition Primers and Toolkits (CADCA) Communities Matter Toolkit (Australia)

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: 19 Oct 2016 07:32:59 -0400
To: Padgett, Jason;Reed, Jerry;Stout, Elly;Robert Gebbia;(b)(6) Stone, Deborah (CDC/ONDIEH/NCIPC);cmoutier@afsp.org
Cc: Rachel Caraballo
Subject: Re: Action Alliance: CBSP section of tomorrow's EXCOM agenda

Hi Jason,
Sounds fine. Do you have the document that Deb provided summarizing the conclusions of our workgroup? Or anything I could use to guide my remarks on that? I can't find it on my account. If not I can wing it.
Thanks,
Jim

Sent from my BlackBerry 10 smartphone.

From: Padgett, Jason
Sent: Tuesday, October 18, 2016 1:26 PM
To: Reed, Jerry; Stout, Elly; Mercy, James (CDC/ONDIEH/NCIPC); Robert Gebbia; (b)(6) Stone, Deborah (CDC/ONDIEH/NCIPC); cmoutier@afsp.org
Cc: Rachel Caraballo
Subject: RE: Action Alliance: CBSP section of tomorrow's EXCOM agenda

Good afternoon all,
BLUF: Jerry will facilitate CBSP section of EXCOM meeting tomorrow. Bob & Jim be prepared to speak to work of your subgroups at EXCOM meeting. Jim be prepared to speak to Technical Package, then later alignment as shared on last call. Presentation will be from your seats
Details: I've attached 2 items.
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Second is the listing that will be in folders of items reviewed.
Safe travels.
Kindly,
-Jason

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Center Operations Director, Center for the Study and Prevention of Injury, Violence and Suicide
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jpadgett@edc.org | Phone: 202-599-0532 | Skype: jason-sprc

EDC Learning transforms lives. Action Alliance for Suicide Prevention

***Envisioning A Nation Free From the Tragic Experience of Suicide ***

-----Original Appointment-----
From: Padgett, Jason

Sent: Thursday, April 28, 2016 3:26 PM
To: Padgett, Jason; Reed, Jerry; Stout, Elly; Belyeu, Avery; Mercy, James (CDC/ONDIEH/NCIPC; Robert Gebbia; (b)(6) Deborah Stone; cmoutier@afsp.org; Melnyk, Liliya
Cc: Rachel Caraballo; Jane Pearson
Subject: Action Alliance: Community-based Suicide Prevention Priority Leadership Team Mtg (2pm Eastern/1pm Central/11am Pacific)
When: Friday, October 14, 2016 1:00 PM-2:00 PM (UTC-06:00) Central Time (US & Canada).
Where: Web-based video conference call (see details far below)
-- Do not delete or change any of the following text. --
Join me now in my Personal Room.
JOIN WEBEX MEETING
https://edc1.webex.com/join/jpadgett | (b)(6)
JOIN BY PHONE
1. Call one of the following numbers:
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From: Padgett, Jason
Sent: 21 Jul 2016 13:26:06 +0000
To: Mercy, James (CDC/ONDIEH/NCIPC);Robert Gebbia;Reed, Jerry;(b)(6) Stone, Deborah (CDC/ONDIEH/NCIPC);cmoutier@afsp.org;Stout, Elly;Melnyk, Liliya;Bird, Doreen;heidi@heidibryan.com;edemello@naminh.org;jarrod.hindman@state.co.us;mruhe@naccho.org;Annmarie_white@urmc.rochester.edu;Zeller, Eileen (SAMHSA/CMHS);Dr. John Harrison;Heather.Stokes@livingworks.net;gigi@gcolombini.com
Subject: RE: Action Alliance: Community-based Suicide Prevention Priority Group Meeting (2pm Eastern/1pm Central/11am Pacific)
Attachments: Final-Assignments.pdf

Per a couple requests, this is a more user-friendly/printable version of the Assignments document as a PDF.

Jason H. Padgett, MPA, MSM
Deputy Secretary, National Action Alliance for Suicide Prevention
Manager of National Partner Initiatives, Suicide Prevention Resource Center
Associate Project Director, EDC, Inc.
jpadgett@edc.org | Phone: 202-599-0532 | Skype: jason-sprc

***Envisioning A Nation Free From the Tragic Experience of Suicide ***

From: Padgett, Jason
Sent: Wednesday, July 20, 2016 5:48 PM
To: 'Mercy, James (CDC/ONDIEH/NCIPC' ; 'Robert Gebbia' ; Reed, Jerry ; (b)(6) ; 'Deborah Stone' ; 'cmoutier@afsp.org' ; Stout, Elly ; Melnyk, Liliya ; Bird, Doreen ; 'heidi@heidibryan.com' ; 'edemello@naminh.org' ; 'jarrod.hindman@state.co.us' ; 'mruhe@naccho.org' ; 'Annmarie_white@urmc.rochester.edu' ; 'Eileen.Zeller@samhsa.hhs.gov' ; Dr. John Harrison ; Heather.Stokes@livingworks.net; 'gigi@gcolombini.com'
Subject: RE: Action Alliance: Community-based Suicide Prevention Priority Group Meeting (2pm Eastern/1pm Central/11am Pacific)

Hello all,

We look forward to Friday's gathering of the CBSP Priority Group at (2pm Eastern/1pm Central/11am Pacific). Based on overall response, we'll continue to use the Webex platform with the understanding that sometimes some members will only be available via phone.

Per preferences of some members, this information is being sent both an Outlook invitation and as an email.

I would highly recommend being on the platform this week as Deb Stone's presentation will be shared on screen, but there is not a handout or attachment related to it.

Attached are three items:

1. Agenda for Friday's full priority group call
2. Assignments document
3. Last message with notes/materials from June's call

The two key goals for Friday's call are to:

1. Better understand the CDC Technical package and how it impacts this work (how is it complementary/aligned; how is it duplicative)
2. Ensure members understand their assignments and reach a decision about how to gather in smaller groups to identify core elements/key lessons from the programs/frameworks/approaches.

As always, if you have questions, concerns, or comments, please let me know.
Kindly,
-Jason

Jason H. Padgett, MPA, MSM
Deputy Secretary, National Action Alliance for Suicide Prevention
Manager of National Partner Initiatives, Suicide Prevention Resource Center
Associate Project Director, EDC, Inc.
jpadgett@edc.org | Phone: 202-599-0532 | Skype: jason-sprc
Envisioning A Nation Free From the Tragic Experience of Suicide *

-- Do not delete or change any of the following text. --

Join me now in my Personal Room.

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https://edc1.webex.com/join/jpadgett | (b)(6)

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Directions

1. Locate your name on the chart. Note the assigned program(s), as well as your corresponding group number (G1, G2, or G3).
2. Search for information on your program(s) with the specific eye toward listing key elements/components of the program(s).
3. Each group has one of the three co-leads and their proxy assigned. We will work with them to identify a time for each group to gather before September 16th to discuss the key components of the full set of programs each group has been assigned. (We can help setup a Doodle poll to help with scheduling needs; or provide a conference line for your conversations).
4. During the group meeting, identify the core elements of the your program(s).
5. On September 23 (regularly scheduled monthly call) be prepared to discuss/present the core elements of your group's program(s).

Questions to help get to what is meant by core elements ...

Q1. Overview of the program/model/framework/approach
Q2. Where and how it has been used (or will be used)
Q3. Evaluation plans or findings
Q4. Take-aways and lessons learned regarding CBSP
>>>>Q4.a. Strategies (what communities should do)
>>>>Q4.b. Process (how communities should do so)

Program/Model/Framework/Approach	Person(s)	Date		
Broad Background items				
CDC Technical Package	Jim/Deb	22-Jul		
SPRC Effective Suicide Prevention	Linda	26-Jun		
Evidence-based Programs			G1	Group 1 members are:
US Air Force Model	Bob/Christine		G1	Lead - Bob/Christine
Help for Life Campaign	Bob/Christine		G1	Doreen
Model Adolescent Suicide Prevention Program	Doreen B.		G1	Eileen
European Alliance Against Depression & OSPI-Europe	Doreen B.		G1	
Other Suicide Prevention Programs			G1	
Garrett Lee Smith Program	Eileen		G1	
SAMHSA NREPP Programs	We are not diving into these as they are not broad community based approaches.		G1	
Other Guidance/Models for Community-Based Prevention				
Suicide Prevention Focused			G2	Group 2 members are:
Colorado	Jarrod		G2	Lead-Jerry/Elly
Communities Matter Toolkit (Australia)	Elaine		G2	Elaine
Connect	Elaine		G2	Heather
IIMHL	Jerry/Elly		G2	Heidi
Living Works Suicide Safer Communities	Heather		G2	Jarrod
New South Wales Framework	Jarrod		G2	
NICE (UK)	Heather		G2	
Texas Suicide Prevention Toolkit (and/or any other state toolkits)	Heidi		G2	
Non-SP Focused				
Channeling Change: Making Collective Impact Work	Elly (per her request)		G2	
Coalition Primers & Toolkits (CADCA)	John		G3	Group 3 members are
Communities that Care (Univ. Washington)	Ann Marie		G3	Lead-Jim/Deb
Community Health Improvement Navigator	Jim/Deb		G3	Ann Marie
Community Tool Box (Univ. Kansas)	Gigi		G3	Gigi
County Health Rankings and Roadmaps Action Cycle (RWJ Foundation)	Melanie		G3	John
Getting to Outcomes	Ann Marie		G3	Melanie
Strategic Prevention Framework	John		G3	

From: Zeller, Eileen (SAMHSA/CMHS)
Sent: 22 Jul 2016 19:37:07 +0000
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Padgett, Jason;Mercy, James (CDC/ONDIEH/NCIPC);Robert Gebbia;Reed, Jerry; (b)(6) moutier@afsp.org;Stout, Elly;Melnyk, Liliya;Bird, Doreen;heidi@heidibryan.com;edemello@naminh.org;jarrod.hindman@state.co.us;mruhe@naccho.org;Annmarie_white@urmc.rochester.edu;Dr. John Harrison;Heather.Stokes@livingworks.net;gigi@gcolombini.com
Subject: RE: Action Alliance: Community-based Suicide Prevention Priority Group Meeting (2pm Eastern/1pm Central/11am Pacific)

Many thanks, Deb!

From: Stone, Deborah (CDC/ONDIEH/NCIPC) [mailto:zaf9@cdc.gov]
Sent: Friday, July 22, 2016 3:32 PM
To: Padgett, Jason; Mercy, James (CDC/ONDIEH/NCIPC); Robert Gebbia; Reed, Jerry; (b)(6) cmoutier@afsp.org; Stout, Elly; Melnyk, Liliya; Bird, Doreen; heidi@heidibryan.com; edemello@naminh.org; jarrod.hindman@state.co.us; mruhe@naccho.org; Annmarie_white@urmc.rochester.edu; Zeller, Eileen (SAMHSA/CMHS); Dr. John Harrison; Heather.Stokes@livingworks.net; gigi@gcolombini.com
Subject: RE: Action Alliance: Community-based Suicide Prevention Priority Group Meeting (2pm Eastern/1pm Central/11am Pacific)

Hi Jason and everyone,

Thanks for the great call today. Here are the two completed Technical Packages to date.

Deb

From: Padgett, Jason [mailto:JPadgett@edc.org]
Sent: Thursday, July 21, 2016 9:26 AM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Robert Gebbia <RGebbia@afsp.org>; Reed, Jerry <jreed@edc.org>; (b)(6) Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; cmoutier@afsp.org; Stout, Elly <estout@edc.org>; Melnyk, Liliya <LMelnyk@edc.org>; Bird, Doreen <DBird@edc.org>; heidi@heidibryan.com; edemello@naminh.org; jarrod.hindman@state.co.us; mruhe@naccho.org; Annmarie_white@urmc.rochester.edu; Zeller, Eileen (SAMHSA/CMHS) <Eileen.Zeller@samhsa.hhs.gov>; Dr. John Harrison <jharrison@cadca.org>; Heather.Stokes@livingworks.net; gigi@gcolombini.com
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From: Padgett, Jason
Sent: Wednesday, July 20, 2016 5:48 PM
To: 'Mercy, James (CDC/ONDIEH/NCIPC' <jam2@cdc.gov>; 'Robert Gebbia' <RGebbia@afsp.org>; Reed, Jerry <jreed@edc.org>; (b)(6) (b)(6) 'Deborah Stone' <zaf9@cdc.gov>; 'cmoutier@afsp.org' <cmoutier@afsp.org>; Stout, Elly <estout@edc.org>; Melnyk, Liliya <LMelnyk@edc.org>; Bird, Doreen <DBird@edc.org>; 'heidi@heidibryan.com' <heidi@heidibryan.com>; 'edemello@naminh.org' <edemello@naminh.org>; 'jarrod.hindman@state.co.us' <jarrod.hindman@state.co.us>; 'mruhe@naccho.org' <mruhe@naccho.org>; 'Annmarie_white@urmc.rochester.edu' <Annmarie_white@urmc.rochester.edu>; 'Eileen.Zeller@samhsa.hhs.gov' <Eileen.Zeller@samhsa.hhs.gov>; Dr. John Harrison <jharrison@cadca.org>; Heather.Stokes@livingworks.net; 'gigi@gcolombini.com' <gigi@gcolombini.com>
Subject: RE: Action Alliance: Community-based Suicide Prevention Priority Group Meeting (2pm Eastern/1pm Central/11am Pacific)

Hello all,

We look forward to Friday's gathering of the CBSP Priority Group at (2pm Eastern/1pm Central/11am Pacific). Based on overall response, we'll continue to use the Webex platform with the understanding that sometimes some members will only be available via phone.

Per preferences of some members, this information is being sent both an Outlook invitation and as an email.

I would highly recommend being on the platform this week as Deb Stone's presentation will be shared on screen, but there is not a handout or attachment related to it.

Attached are three items:

1. Agenda for Friday's full priority group call
2. Assignments document
3. Last message with notes/materials from June's call

The two key goals for Friday's call are to:

1. Better understand the CDC Technical package and how it impacts this work (how is it complementary/aligned; how is it duplicative)
2. Ensure members understand their assignments and reach a decision about how to gather in smaller groups to identify core elements/key lessons from the programs/frameworks/approaches.

As always, if you have questions, concerns, or comments, please let me know.

Kindly,

-Jason

Jason H. Padgett, MPA, MSM
Deputy Secretary, National Action Alliance for Suicide Prevention
Manager of National Partner Initiatives, Suicide Prevention Resource Center
Associate Project Director, EDC, Inc.
jpadgett@edc.org | Phone: 202-599-0532 | Skype: jason-sprc
***Envisioning A Nation Free From the Tragic Experience of Suicide ***

-- Do not delete or change any of the following text. --

Join me now in my Personal Room.

JOIN WEBEX MEETING
https://edc1.webex.com/join/jpadgett | (b)(6)

JOIN BY PHONE
1. Call one of the following numbers:
1-617-618-2000 : Audio and Web Conferencing
2. Follow the instructions that you hear on the phone:
Cisco Unified MeetingPlace meeting ID: (b)(6)
Access code: (b)(6)

Can't join the meeting? Contact support here:
https://edc1.webex.com/mc

IMPORTANT NOTICE: Please note that this WebEx service allows audio and other information sent during the session to be recorded, which may be discoverable in a legal matter. By joining this session, you automatically consent to such recordings. If you do not consent to being recorded, discuss your concerns with the host or do not join the session.

From: Robert Gebbia
Sent: 1 Nov 2016 23:31:03 +0000
To: Padgett, Jason;Mercy, James (CDC/ONDIEH/NCIPC);Reed, Jerry; (b)(6) Stone, Deborah (CDC/ONDIEH/NCIPC);Christine Moutier;Stout, Elly;Carr, Colleen;Belyeu, Avery
Cc: Rachel Caraballo
Subject: RE: Action Alliance: Community-based Suicide Prevention Priority Leadership Team Mtg (2pm Eastern/1pm Central/11am Pacific)

Thanks Jason, the agenda looks good to me.
Bob

Sent from my Verizon, Samsung Galaxy smartphone

-------- Original message --------
From: "Padgett, Jason"
Date: 11/1/16 5:40 PM (GMT-05:00)
To: "Mercy, James (CDC/ONDIEH/NCIPC" , Robert Gebbia , "Reed, Jerry" , (b)(6) Deborah Stone , Christine Moutier , "Stout, Elly" , "Carr, Colleen" , "Belyeu, Avery"
Cc: Rachel Caraballo
Subject: RE: Action Alliance: Community-based Suicide Prevention Priority Leadership Team Mtg (2pm Eastern/1pm Central/11am Pacific)

Good evening all,
Below is a suggested agenda for the call for this Friday at 2pm ET/1pm CT.

- Staff liaison transition – *Jason*
- Summary of EXCOM Meeting – *Bob, Jim, & Jerry*
- Option of potential next steps:
    - Alignment with Zero Suicide- *Jerry*
    - Alignment with CDC Technical Package- *Jim*
    - Awareness of CARF/VA/DSPO Initiative- *Jerry*
    - Getting input on elements from community stakeholders – *Jerry/Elly*
- Planning Call for November 18th- *Avery*

Are there any other items that you would like to add to this agenda? If so, please send those agenda items to Avery Belyeu (abelyeu@edc.org) by COB on Thursday, November 3rd.
I am looking forward to connecting with you on Friday.
Kindly,
-Jason
Jason H. Padgett, MPA, MSM
Center Operations Director

Center for the Study and Prevention of Injury, Violence and Suicide
EDC, Inc.
jpadgett@edc.org | Phone: 202-599-0532 | Skype: jason-sprc

EDC Learning transforms lives.

-----Original Appointment-----
From: Padgett, Jason
Sent: Thursday, April 28, 2016 3:26 PM
To: Padgett, Jason; Mercy, James (CDC/ONDIEH/NCIPC; Robert Gebbia; Reed, Jerry; (b)(6) Deborah Stone; cmoutier@afsp.org; Stout, Elly; Carr, Colleen; Belyeu, Avery
Cc: Rachel Caraballo
Subject: Action Alliance: Community-based Suicide Prevention Priority Leadership Team Mtg (2pm Eastern/1pm Central/11am Pacific)
When: Friday, November 4, 2016 1:00 PM-2:00 PM (UTC-06:00) Central Time (US & Canada).
Where: Web-based video conference call (see details far below)
Importance: High
Got several OK's to move, talk to all available on Friday.

-- Do not delete or change any of the following text. --

Join me now in my Personal Room.

Join WebEx meeting
https://edc1.webex.com/join/jpadgett | (b)(6)

Join by phone
1. Call one of the following numbers:
1-617-618-2000 : Audio and Web Conferencing
2. Follow the instructions that you hear on the phone:
Cisco Unified MeetingPlace meeting ID: (b)(6)
Access code: (b)(6)

Can't join the meeting? Contact support.

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From: Pearson, Jane L (NIH/NIMH) [E]
Sent: 21 Feb 2017 20:46:11 +0000
To: Reed, Jerry;Stone, Deborah (CDC/ONDIEH/NCIPC);Robert Gebbia;McKeon, Richard (SAMHSA/CMHS)
Cc: McGowan, Angela (OS/OASH)
Subject: RE: APHA?

Hi Deb,
This is a great idea, but I think I am calendar challenged, and will likely be in Nevada. The JAMA report today is a clear illustration of how policy can affect adolescent suicide risk:
http://jamanetwork.com/journals/jamapediatrics/fullarticle/2604258
Could do the same with NSDUH data…
APHA is in Atlanta Nov 4-8
https://www.apha.org/annualmeeting
IASR/AFSP mtg is in Henderson NV Nov 5-8
http://suicideresearchsummit.org/
I can see if Belinda Sims (NIDA) or Eve Reider (NCCIH) are interested in the upstream youth suicide prevention efforts for this.
Jane

From: Reed, Jerry [mailto:jreed@edc.org]
Sent: Tuesday, February 21, 2017 12:29 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Robert Gebbia ; Pearson, Jane L (NIH/NIMH) [E] ; McKeon, Richard (SAMHSA/CMHS)
Cc: McGowan, Angela (OS/OASH)
Subject: RE: APHA?
I would be interested if others are.
Jerry

Jerry Reed, Ph.D., MSW
Senior Vice President for Practice Leadership & Director,
Center for the Study and Prevention of
Injury, Violence and Suicide
EDC
1025 Thomas Jefferson Street, Suite 700W
Washington, DC 20007
jreed@edc.org
(202) 572-3771 (direct)
(202) 223-4059
(202) 294-8132 (cell)



From: Stone, Deborah (CDC/ONDIEH/NCIPC) [mailto:zaf9@cdc.gov]
Sent: Tuesday, February 21, 2017 11:32 AM
To: Robert Gebbia <RGebbia@afsp.org>; Pearson, Jane L (NIH/NIMH) [E] <jpearson@mail.nih.gov>; McKeon, Richard (SAMHSA/CMHS) <Richard.McKeon@samhsa.hhs.gov>
Cc: McGowan, Angela (OS/OASH) <Angela.Mcgowan@hhs.gov>; Reed, Jerry <jreed@edc.org>
Subject: APHA?
Hi Bob, Jane, and Richard,

The MHMD law and health policy project did decide to go ahead and submit an abstract to APHA.
As part of the discussion about submitting an abstract we considered the idea of submitting abstracts for a special session. Ultimately, given the short turnaround time from the idea to the submission deadline (this Fri) we decided not to go that route.
However, APHA has since extended the deadline by a week so we are now revisiting this option.
To that end, I was wondering if you had already submitted an abstract (or session) and/or if you'd be interested in putting together a session??
One possibility for a session topic, again if it's not already been put forward and submitted, could be roughly around comprehensive suicide prevention as a means of reaching suicide prevention benchmarks (AFSP/Action Alliance and HP2020).
The session, comprised of 4-5 abstracts could include the MHMD report, CDC Technical Package, and AFSP initiatives toward the 2025 goal. The other 1-2 abstracts could include the SAMHSA's NSSP work and/or Action Alliance's Community Based Suicide Prev initiative and/or the Colorado initiative.
Session abstracts include individual abstracts (which include an abstract plus an expanded abstract per the Injury Section guidelines) plus a one page overview of the session along with a number of other requirements about conflict of interest statements, etc.
Cc'ing Angie since she is coordinating the initial submission and Jerry since he may also be interested given his role across some of these projects. Decided not to cc Kate for the time being since she's on vacation.
Thoughts?
Thanks,
Deb

Deb Stone
Behavioral Scientist
National Center for Injury Prevention and Control
Division of Violence Prevention
Research & Evaluation Branch
Youth Violence, Suicide, and Elder Maltreatment Team
10th fl, Room 10030
M, Th, 617.429.3827
T, W, F 770.488.3942
dstone3@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 21 Feb 2017 22:46:16 +0000
To: Robert Gebbia
Subject: RE: APHA?

Hi Bob,
Do you think the IASR/AFSP conference would be interested in our proposed session if we decided to move to that venue instead of APHA?
Deb

From: Robert Gebbia [mailto:RGebbia@afsp.org]
Sent: Tuesday, February 21, 2017 4:58 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Pearson, Jane L (NIH/NIMH) [E] ; McKeon, Richard (SAMHSA/CMHS)
Cc: McGowan, Angela (OS/OASH) ; Reed, Jerry ; Christine Moutier
Subject: RE: APHA?

Hi Deb,
Unfortunately this conference overlaps with the 2017 International Summit on Suicide Research co-sponsored by AFSP and IASR (International Academy of Suicide Research), which is on November 5-8.
Christine, Jill and I will all be at the Research Summit. Perhaps Someone else from AFSP could participate.
Bob

From: Stone, Deborah (CDC/ONDIEH/NCIPC) [mailto:zaf9@cdc.gov]
Sent: Tuesday, February 21, 2017 11:32 AM
To: Robert Gebbia; Pearson, Jane L (NIH/NIMH) [E]; McKeon, Richard (SAMHSA/CMHS)
Cc: McGowan, Angela (OS/OASH); Reed, Jerry
Subject: APHA?

Hi Bob, Jane, and Richard,
The MHMD law and health policy project did decide to go ahead and submit an abstract to APHA.
As part of the discussion about submitting an abstract we considered the idea of submitting abstracts for a special session. Ultimately, given the short turnaround time from the idea to the submission deadline (this Fri) we decided not to go that route.
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10th fl, Room 10030
M, Th, 617.429.3827
T, W, F 770.488.3942
dstone3@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 25 Jul 2017 19:49:43 +0000
To: Reed, Jerry;Gebbia, Robert;Mercy, James (CDC/ONDIEH/NCIPC);Belyeu, Avery;Padgett, Jason;Stout, Elly
Subject: RE: CDC Foundation Grant Discussion

Hi Jerry,
Thanks for your email. I'm sure Jim will respond when he's available but glad to hear that you think Colorado is a viable option.
Deb

From: Reed, Jerry [mailto:jreed@edc.org]
Sent: Tuesday, July 25, 2017 10:18 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Gebbia, Robert ; Mercy, James (CDC/ONDIEH/NCIPC) ; Belyeu, Avery ; Padgett, Jason ; Stout, Elly
Subject: CDC Foundation Grant Discussion

Dear Colleagues,
After much thought last evening, I am writing to suggest that in fact the communities in Colorado (3-4) that are being identified to participate in the CNC may be the ideal communities to test applying our framework and technical package with. At first I thought better to see a completely new source but now I think if we worked with these 3-4 communities as to how to assemble the right kind of team based on their burden data and then select an EBP that is suitable to reducing burden, we would be able to demonstrate hopefully how important following the process outlined in the CBSP framework really is. I am writing to let you know I am not of a somewhat different mind and would not rule out working with the Colorado communities. Open to your thoughts.
Best,
Jerry

Jerry Reed, PhD, MSW
jreed@edc.org | 202-572-3771 (O) | 202-294-8132 (M) | 202-223-4059 (F)

Senior Vice President for Practice Leadership & Director for the Injury, Violence, and Suicide Prevention Portfolio EDC, Inc.	Director Suicide Prevention Resource Center	Co-Director Injury Control Research Center for Suicide Prevention	Executive Committee Member National Action Alliance for Suicide Prevention

From: Robert Gebbia
Sent: 25 Jul 2017 20:38:07 +0000
To: Reed, Jerry;Stone, Deborah (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Belyeu, Avery;Padgett, Jason;Stout, Elly
Subject: RE: CDC Foundation Grant Discussion

Jerry,
I think are advantages to testing this in Colorado, and would support this approach.
Bob

From: Reed, Jerry [mailto:jreed@edc.org]
Sent: Tuesday, July 25, 2017 10:18 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC); Robert Gebbia; Mercy, James (CDC/ONDIEH/NCIPC); Belyeu, Avery; Padgett, Jason; Stout, Elly
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Senior Vice President for Practice Leadership & Director for the Injury, Violence, and Suicide Prevention Portfolio EDC, Inc.	Director Suicide Prevention Resource Center	Co-Director Injury Control Research Center for Suicide Prevention	Executive Committee Member National Action Alliance for Suicide Prevention
EDC Learning transforms lives.	SPRC	ICRC-S	Action Alliance

From: Robert Gebbia
Sent: 24 Oct 2016 22:01:01 +0000
To: Padgett, Jason;Mercy, James (CDC/ONDIEH/NCIPC);Reed, Jerry
Cc: Christine Moutier;Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;(b)(6);Rachel Caraballo
Subject: RE: Decision requested: Action Alliance: Community-based Suicide Prevention Full Group Call

Thanks Jason. I agree and support option C.
Option B would make sense if there are items you want to discuss with the leadership team prior to working on a plan for gathering input and aligning with CDC technical package.
Bob

From: Padgett, Jason [mailto:JPadgett@edc.org]
Sent: Monday, October 24, 2016 9:38 AM
To: Mercy, James (CDC/ONDIEH/NCIPC; Reed, Jerry; Robert Gebbia
Cc: Christine Moutier; Deborah Stone; Stout, Elly; (b)(6) Rachel Caraballo
Subject: Decision requested: Action Alliance: Community-based Suicide Prevention Full Group Call

Good morning all,

BLUF: Maintain, cancel or change purpose of Friday's scheduled meeting of the Transforming Communities group.

First, many thanks to Bob, Jim, and Jerry for presenting at the EXCOM meeting last week. Second, much appreciation to all of you for moving efforts forward over the past few months.

As you may see on your calendars, we have a full group call scheduled for Friday afternoon. However, I think our only information to share/discuss at this point could be a brief summary about activity since the face-to-face meeting (desire to align with CDC Technical package release; gain more input from community leaders such as a few AFSP chapters or few communities within states). Therefore, I am wondering which of the following this you, as the co-leads, would prefer:

a. Maintain scheduled meeting and keep it brief
b. Change it to a leadership meeting to better plot out alignment and input gathering
c. Cancel it which would allow for time to prepare a plan for gathering input and aligning with CDC technical package.

Please let me know if you prefer A, B, or C. **I lean towards/recommend C.** However, I can make a case for B, as well as A. Once I hear back from a few and (if) there appears to be alignment, I'll update the full group.

Either way, we'll need to extend meetings of the leadership team and full group a few months to complete the work.

Kindly,
-Jason

Jason H. Padgett, MPA, MSM
Center Operations Director
Center for the Study and Prevention of Injury, Violence and Suicide
EDC, Inc.
jpadgett@edc.org | Phone: 202-599-0532 | Skype: jason-sprc



From: Padgett, Jason
Sent: 24 Oct 2016 22:24:02 +0000
To: Robert Gebbia;Mercy, James (CDC/ONDIEH/NCIPC);Reed, Jerry
Cc: Christine Moutier;Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly (b)(6) Rachel Caraballo;Carr, Colleen
Subject: RE: Decision requested: Action Alliance: Community-based Suicide Prevention Full Group Call

Based on inputs, I'm going to let the full group know we are cancelling Friday. I'll extend our meetings into January – 2nd Friday for leadership group; 3rd Friday for full group. Modified to 3rd to avoid Thanksgiving and Christmas which are impacted by 4th Friday's.
Kindly,
-Jason
Jason H. Padgett, MPA, MSM
Center Operations Director
Center for the Study and Prevention of Injury, Violence and Suicide
EDC, Inc.
jpadgett@edc.org | Phone: 202-599-0532 | Skype: jason-sprc

EDC Learning transforms lives.

From: Robert Gebbia [mailto:RGebbia@afsp.org]
Sent: Monday, October 24, 2016 5:01 PM
To: Padgett, Jason ; Mercy, James (CDC/ONDIEH/NCIPC ; Reed, Jerry
Cc: Christine Moutier ; Deborah Stone ; Stout, Elly ; (b)(6) Rachel Caraballo
Subject: RE: Decision requested: Action Alliance: Community-based Suicide Prevention Full Group Call

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Sent: Monday, October 24, 2016 9:38 AM
To: Mercy, James (CDC/ONDIEH/NCIPC; Reed, Jerry; Robert Gebbia
Cc: Christine Moutier; Deborah Stone; Stout, Elly; (b)(6) Rachel Caraballo
Subject: Decision requested: Action Alliance: Community-based Suicide Prevention Full Group Call

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Please let me know if you prefer A, B, or C. **I lean towards/recommend C.** However, I can make a case for B, as well as A. Once I hear back from a few and (if) there appears to be alignment, I'll update the full group.
Either way, we'll need to extend meetings of the leadership team and full group a few months to complete the work.
Kindly,
-Jason
Jason H. Padgett, MPA, MSM
Center Operations Director
Center for the Study and Prevention of Injury, Violence and Suicide
EDC, Inc.
jpadgett@edc.org | Phone: 202-599-0532 | Skype: jason-sprc



From: Reed, Jerry
Sent: 30 Nov 2017 15:32:55 +0000
To: Crosby, Alexander (CDC/ONDIEH/NCIPC);Hindman - CDPHE, Jarrod
Cc: Kyle Brown - GovOffice;Betz, Marian;Allen, Michael;Runyan, Carol;Sarah Brummett - CDPHE;Gutierrez, Peter M. <Peter.Gutierrez@va.gov>;Brian Turner;Ethan Jamison - CDPHE;Bol, Kirk;Emily Fine - CDPHE;Barb Becker;Gebbia, Robert;Schoenbaum, Michael (NIH/NIMH) [C];McKeon, Richard (SAMHSA/CMHS);Quinlan, Kristen;Caine, Eric;White, AnnMarie;Conwell, Yeates;Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Subject: RE: Detailed agendas - CDC tech pkg

Yes, I will handle the transforming document. I'll send slides in advance. I'll work on them today.
Best,
Jerry

Jerry Reed, PhD, MSW
Senior Vice President for Practice Leadership
Injury, Violence & Suicide Prevention Portfolio Lead
National Action Alliance for Suicide Prevention Executive Committee Member
jreed@edc.org | 202-572-3771 (O) | 202-294-8132 (M) | 202-223-4059 (F)
Education Development Center, Inc.



From: Crosby, Alexander (CDC/ONDIEH/NCIPC) [mailto:aec1@cdc.gov]
Sent: Thursday, November 30, 2017 10:00 AM
To: Hindman - CDPHE, Jarrod
Cc: Kyle Brown - GovOffice ; Betz, Marian ; Allen, Michael ; Runyan, Carol ; Sarah Brummett - CDPHE ; Gutierrez, Peter M. ; Brian Turner ; Ethan Jamison - CDPHE ; Bol, Kirk ; Emily Fine - CDPHE ; Barb Becker ; Gebbia, Robert ; Schoenbaum, Michael (NIH/NIMH) [C] ; McKeon, Richard (SAMHSA/CMHS) ; Quinlan, Kristen ; Caine, Eric ; Reed, Jerry ; White, AnnMarie ; Conwell, Yeates ; Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Subject: RE: Detailed agendas - CDC tech pkg

Greetings:
Yes, I will handle the tech pkg. I'll send slides in a little while.
Alex C

From: Hindman - CDPHE, Jarrod [mailto:jarrod.hindman@state.co.us]
Sent: Wednesday, November 29, 2017 6:32 PM
To: Sarah Brummett - CDPHE <sarah.brummett@state.co.us>; Gutierrez, Peter M. <Peter.Gutierrez@va.gov> <Peter.Gutierrez@va.gov>; Brian Turner <bturner@cbhc.org>; Ethan Jamison - CDPHE <ethan.jamison@state.co.us>; Bol, Kirk <kirk.bol@state.co.us>; Emily Fine - CDPHE <emily.fine@state.co.us>; Barb Becker <bbecker@cbhc.org>; Gebbia, Robert <RGebbia@afsp.org>; Schoenbaum, Michael (NIH/NIMH) [C] <schoenbaumm@mail.nih.gov>; McKeon, Richard (SAMHSA/CMHS) <Richard.McKeon@samhsa.hhs.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Quinlan, Kristen <KQuinlan@edc.org>; Caine, Eric <Eric_Caine@urmc.rochester.edu>; Reed, Jerry <jreed@edc.org>; White, AnnMarie <AnnMarie_White@urmc.rochester.edu>; Conwell, Yeates <Yeates_Conwell@urmc.rochester.edu>; Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC) <dcz0@cdc.gov>
Cc: Kyle Brown - GovOffice <kylem.brown@state.co.us>; Betz, Marian <MARIAN.BETZ@ucdenver.edu>; Allen, Michael <Michael.Allen@ucdenver.edu>; Runyan, Carol <CAROL.RUNYAN@ucdenver.edu>
Subject: Detailed agendas

Attached. Let me know what I've missed and/or what needs to be amended.
Alex / Shakiyla - Can one of you present on the Technical Package?

Jerry / Bob - Can one of you present on the Transforming Communities doc?
Ethan / Kirk - note the data presentation section and let me know if anything needs to be tweaked.
FYI. . . I just sent these to local partner leaders as well, so there may be some adjustments. I'll keep you posted if so.
Thank you.
Jarrod

--

Jarrod Hindman, MS

Deputy Chief

Violence and Injury Prevention-Mental Health Promotion Branch



P 303.692.2539 | F 303.691.7901

4300 Cherry Creek Drive South, Denver CO 80246

jarrod.hindman@state.co.us |

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 17 Feb 2017 22:05:22 +0000
To: 'Belyeu, Avery';Mercy, James (CDC/ONDIEH/NCIPC);Reed, Jerry;Robert Gebbia
Cc: Caraballo, Rachel;cmoutier (cmoutier@afsp.org);Stout, Elly;Magdala Labre;Melissa Helm
Subject: RE: Proposed Webinar Dates: Transforming Communities and CDC Tech Package

Either of those times will work for me. Thanks for coordinating.
Deb

From: Belyeu, Avery [mailto:ABelyeu@edc.org]
Sent: Friday, February 17, 2017 4:40 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) ; Reed, Jerry ; Robert Gebbia
Cc: Caraballo, Rachel ; cmoutier (cmoutier@afsp.org) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Stout, Elly ; Magdala Labre ; Melissa Helm
Subject: Proposed Webinar Dates: Transforming Communities and CDC Tech Package

Dear Community Based Suicide Prevention Co-leads,

We have identified two potential dates for a public webinar regarding the Transforming Communities Paper and the CDC Technical Package.

- **Tuesday, March 28th , 2-3:30 ET**
- **Wednesday April 12th , 3-4:30 ET**

Please respond to this email with your availability. I look forward to working with you on next steps.

My Best,
Avery

Avery Belyeu
National Partnerships Associate
National Action Alliance for Suicide Prevention
The Education Development Center (EDC)
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
(828) 406-4029 (Direct)

SPRC EDC Learning transforms lives.

From: Robert Gebbia
Sent: 18 Feb 2017 03:23:27 +0000
To: Belyeu, Avery;Mercy, James (CDC/ONDIEH/NCIPC);Reed, Jerry
Cc: Caraballo, Rachel;Christine Moutier;Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;Magdala Labre;Melissa Helm
Subject: RE: Proposed Webinar Dates: Transforming Communities and CDC Tech Package

Both of these dates are good for me.
Bob

Sent from my Verizon, Samsung Galaxy smartphone

-------- Original message --------
From: "Belyeu, Avery"
Date: 2/17/17 4:40 PM (GMT-05:00)
To: "Mercy, James (CDC/ONDIEH/NCIPC)" , "Reed, Jerry" , Robert Gebbia
Cc: "Caraballo, Rachel" , Christine Moutier , "Deborah Stone (zaf9@cdc.gov)" , "Stout, Elly" , Magdala Labre , Melissa Helm
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Washington, DC 20007
(828) 406-4029 (Direct)



From: Melissa Helm
Sent: 21 Feb 2017 16:54:49 +0000
To: Belyeu, Avery;Mercy, James (CDC/ONDIEH/NCIPC);Reed, Jerry;Robert Gebbia
Cc: Caraballo, Rachel;Christine Moutier;Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;Magdala Labre
Subject: RE: Proposed Webinar Dates: Transforming Communities and CDC Tech Package

Hi Avery,
Christine is unavailable for both the dates provided. She let me know it is OK to move forward scheduling without her.
Best,
Melissa

Melissa Helm
Executive Assistant to Robert Gebbia and Christine Moutier, MD
American Foundation for Suicide Prevention
120 Wall Street | 29th floor | New York, NY 10005
mhelm@afsp.org
T: 212-363-3500 x2018



From: Belyeu, Avery [mailto:ABelyeu@edc.org]
Sent: Friday, February 17, 2017 4:40 PM
To: Mercy, James (CDC/ONDIEH/NCIPC); Reed, Jerry; Robert Gebbia
Cc: Caraballo, Rachel; Christine Moutier; Deborah Stone (zaf9@cdc.gov); Stout, Elly; Magdala Labre; Melissa Helm
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National Partnerships Associate
National Action Alliance for Suicide Prevention
The Education Development Center (EDC)
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
(828) 406-4029 (Direct)



From: Belyeu, Avery
Sent: 21 Feb 2017 18:45:36 +0000
To: Melissa Helm;Mercy, James (CDC/ONDIEH/NCIPC);Reed, Jerry;Robert Gebbia
Cc: Caraballo, Rachel;Christine Moutier;Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;Magdala Labre
Subject: RE: Proposed Webinar Dates: Transforming Communities and CDC Tech Package

Thank you, Melissa.
My Best,
Avery

From: Melissa Helm [mailto:MHelm@afsp.org]
Sent: Tuesday, February 21, 2017 10:55 AM
To: Belyeu, Avery ; Mercy, James (CDC/ONDIEH/NCIPC) ; Reed, Jerry ; Robert Gebbia
Cc: Caraballo, Rachel ; Christine Moutier ; Deborah Stone (zaf9@cdc.gov) ; Stout, Elly ; Magdala Labre
Subject: RE: Proposed Webinar Dates: Transforming Communities and CDC Tech Package

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mhelm@afsp.org
T: 212-363-3500 x2018



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Sent: Friday, February 17, 2017 4:40 PM
To: Mercy, James (CDC/ONDIEH/NCIPC); Reed, Jerry; Robert Gebbia
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1025 Thomas Jefferson St, St.700W
Washington, DC 20007
(828) 406-4029 (Direct)



From: Padgett, Jason
Sent: 23 May 2016 20:36:30 +0000
To: Christine Moutier;Reed, Jerry;Mercy, James (CDC/ONDIEH/NCIPC);Robert Gebbia (b)(6) tone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;Chervin, Doryn;Melnyk, Liliya
Subject: RE: Suicide Technical Package and the White Paper on a Comprehensive, Community-based Approach to Suicide Prevention

Just a technical note – I'm going to be sending out the agenda for Friday's call to the co-leads tomorrow for edits (some final touches coming later today). However, the agenda is full (broad overview, welcome, introductions, work plan review, sample outline for a white paper, presentation and discussion about the SPRC effective suicide prevention model, and review of action items/next steps) --- we can have the CDC technical package as a key topic area for the June call. IF when you see the agenda tomorrow and you believe we could fit it in Friday, great. If not, please, know it's on the plan for June.

Jason H. Padgett, MPA, MSM
Deputy Secretary, National Action Alliance for Suicide Prevention
Manager of National Partner Initiatives, Suicide Prevention Resource Center
Associate Project Director, Education Development Center, Inc. (EDC)
jpadgett@edc.org | Phone: 202-599-0532 | Skype: jason-sprc

***Envisioning A Nation Free From the Tragic Experience of Suicide ***

From: Christine Moutier [mailto:CMoutier@afsp.org]
Sent: Monday, May 23, 2016 3:27 PM
To: Reed, Jerry ; Mercy, James (CDC/ONDIEH/NCIPC) ; Padgett, Jason ; Robert Gebbia ; (b)(6) Stone, Deborah (CDC/ONDIEH/NCIPC) ; Stout, Elly ; Chervin, Doryn ; Melnyk, Liliya
Subject: RE: Suicide Technical Package and the White Paper on a Comprehensive, Community-based Approach to Suicide Prevention

Thanks, Jim. The technical package for child abuse & neglect is a wonderful document. How do you think education/health/advocacy groups will use it? I might be catching up with others on this, and some fleshing out of examples for how these packages, including ours on Suicide Prevention, will be used will be helpful.

Thanks,
Christine

Christine Moutier, M.D.
Chief Medical Officer
American Foundation for Suicide Prevention
120 Wall Street
New York, NY 10005
212-363-3500 x2017

From: Reed, Jerry [jreed@edc.org]
Sent: Monday, May 23, 2016 3:00 PM
To: Mercy, James (CDC/ONDIEH/NCIPC); Padgett, Jason; Robert Gebbia; (b)(6) Stone, Deborah

(CDC/ONDIEH/NCIPC); Christine Moutier; Stout, Elly; Chervin, Doryn; Melnyk, Liliya
Subject: RE: Suicide Technical Package and the White Paper on a Comprehensive, Community-based Approach to Suicide Prevention

Thanks Jim. Very helpful. I have reviewed the Technical Package you sent and feel what is important for our next call is to discuss how does our product differs from what will be coming in the suicide prevention Technical Package. No need to duplicate or recreate the wheel. Having reviewed what you sent, I have some thoughts but would strongly encourage others to review so we can zero in on what the field needs and what we can create that will help.
Best,
Jerry

Jerry Reed, Ph.D., MSW
Vice President & Director
Center for the Study and Prevention of
Injury, Violence and Suicide
EDC
1025 Thomas Jefferson Street, Suite 700W
Washington, DC 20007
jreed@edc.org
(202) 572-3771 (direct)
(202) 223-4059
(202) 294-8132 (cell)



From: Mercy, James (CDC/ONDIEH/NCIPC) [mailto:jam2@cdc.gov]
Sent: Monday, May 23, 2016 2:40 PM
To: Padgett, Jason <JPadgett@edc.org>; Robert Gebbia <RGebbia@afsp.org>; Reed, Jerry <jreed@edc.org>; (b)(6) Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; cmoutier@afsp.org; Stout, Elly <estout@edc.org>; Chervin, Doryn <DChervin@edc.org>; Melnyk, Liliya <LMelnyk@edc.org>
Subject: Suicide Technical Package and the White Paper on a Comprehensive, Community-based Approach to Suicide Prevention

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If you have any questions please let me know.
Best,
Jim

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: 24 May 2016 08:02:42 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);'Christine Moutier';Reed, Jerry;Padgett, Jason;Robert Gebbia;[(b)(6)]tout, Elly;Chervin, Doryn;Melnyk, Liliya
Subject: RE: Suicide Technical Package and the White Paper on a Comprehensive, Community-based Approach to Suicide Prevention

Thanks Deb, I would add that we also see these packages as resources for the field in general (e.g., communities, foundations, other federal agencies, etc.) and hope it contributes to a broader sense that we have sufficient evidence to take action to prevent suicide as the urgency to take action builds.
As Deb said what these packages don't address is how one goes about implementing the actions described within. So that is an important aspect that we'll be developing after we release each package.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, May 23, 2016 7:11 PM
To: 'Christine Moutier' ; Reed, Jerry ; Mercy, James (CDC/ONDIEH/NCIPC) ; Padgett, Jason ; Robert Gebbia ; [(b)(6)] Stout, Elly ; Chervin, Doryn ; Melnyk, Liliya
Subject: RE: Suicide Technical Package and the White Paper on a Comprehensive, Community-based Approach to Suicide Prevention

Hi Christine,
I'll jump in for Jim and he can correct me if I'm wrong. The technical package will be disseminated to states as a resource to guide suicide prevention decision-making. The expectation is that different sectors (such as education and public health) within a state or community would take the lead on various components. Together the strategies support coordinated and comprehensive suicide prevention and they are being developed with the national strategy in mind. Implementation guidance will be sent to states separately to address more of the particulars.
It will be interesting to consider this work in the context of the CBSP and other efforts such as the SPRC model. I look forward to the discussions to come, be they in May or June (per Jason's email).
Deb

From: Christine Moutier [mailto:CMoutier@afsp.org]
Sent: Monday, May 23, 2016 4:27 PM
To: Reed, Jerry <jreed@edc.org>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Padgett, Jason <JPadgett@edc.org>; Robert Gebbia <RGebbia@afsp.org>; [(b)(6)] Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Stout, Elly <estout@edc.org>; Chervin, Doryn <DChervin@edc.org>; Melnyk, Liliya <LMelnyk@edc.org>
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Sent: Monday, May 23, 2016 3:00 PM
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EDC Learning transforms lives.

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Sent: Monday, May 23, 2016 2:40 PM
To: Padgett, Jason <JPadgett@edc.org>; Robert Gebbia <RGebbia@afsp.org>; Reed, Jerry <jreed@edc.org>; (b)(6) Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; cmoutier@afsp.org; Stout, Elly <estout@edc.org>; Chervin, Doryn <DChervin@edc.org>; Melnyk, Liliya <LMelnyk@edc.org>
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If you have any questions please let me know.
Best,
Jim

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: 15 Dec 2017 10:05:44 -0500
To: Brummett - CDPHE, Sarah
Cc: Hindman - CDPHE, Jarrod;Betz, Marian;cc: Runyan, Carol;Allen, Michael;cc: Kyle Brown - GovOffice;Stone, Deborah (CDC/ONDIEH/NCIPC);Wilkins, Natalie J. (CDC/ONDIEH/NCIPC);Gutierrez, Peter M. <Peter.Gutierrez@va.gov>;Brian Turner;Ethan Jamison - CDPHE;Bol, Kirk;Emily Fine - CDPHE;Barb Becker;Gebbia, Robert;Schoenbaum, Michael (NIH/NIMH) [C];McKeon, Richard (SAMHSA/CMHS);Quinlan, Kristen;Caine, Eric;Reed, Jerry;White, AnnMarie;Conwell, Yeates;Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Subject: Re: Thank you!

Greetings:
Thank you for the response. Just checking to make sure that that sector is represented.
Alex C

Sent from my BlackBerry 10 smartphone.
From: Brummett - CDPHE, Sarah
Sent: Friday, December 15, 2017 09:53
To: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Hindman - CDPHE, Jarrod; Betz, Marian; cc: Runyan, Carol; Allen, Michael; cc: Kyle Brown - GovOffice; Stone, Deborah (CDC/ONDIEH/NCIPC); Wilkins, Natalie J. (CDC/ONDIEH/NCIPC); Gutierrez, Peter M. ; Brian Turner; Ethan Jamison - CDPHE; Bol, Kirk; Emily Fine - CDPHE; Barb Becker; Gebbia, Robert; Schoenbaum, Michael (NIH/NIMH) [C]; McKeon, Richard (SAMHSA/CMHS); Quinlan, Kristen; Caine, Eric; Reed, Jerry; White, AnnMarie; Conwell, Yeates; Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Subject: Re: Thank you!

Alex,

Sifting through my email and I didn't see a response to your question, apologies for the delay. Yes, Paul Bretz is still actively involved and continues to serve as the private co-chair for the Suicide Prevention Commission. He and Emily had a really good meeting with Ms. Warren down in Colorado Springs a few weeks ago and I heard that ideas and connections are brewing.

--

Sarah Brummett, M.A., J.D.
Office of Suicide Prevention Director
Violence and Injury Prevention-Mental Health Promotion Branch

COLORADO
Department of Public Health & Environment

P 303-692-2369 | F 303.691.7901
4300 Cherry Creek Drive South, Denver CO 80246
sarah.brummett@state.co.us | www.coosp.org

If you or someone you know is in need of support please contact the Colorado Crisis and Support Line at 1-844-493-TALK (8255) or text "TALK" to 38255 or go to www.coloradocrisisservices.org to access chat. Help and hope are available 24 / 7 / 365

On Tue, Dec 12, 2017 at 7:20 AM, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov> wrote:

Greetings:

You are quite welcome. It was a very worthwhile & important set of visits.

One consideration that I had was the involvement of the faith-based organizations. I think that group was mentioned at all three locations but I only recall 1 representative which was at the El Paso site. I was wondering about making sure that others such as Ms Warren & Mr Bretz are still involved.

Alex C

From: Hindman - CDPHE, Jarrod [mailto:jarrod.hindman@state.co.us]
Sent: Monday, December 11, 2017 5:44 PM
To: Sarah Brummett - CDPHE <sarah.brummett@state.co.us>; Gutierrez, Peter M. <Peter.Gutierrez@va.gov> <Peter.Gutierrez@va.gov>; Brian Turner <bturner@cbhc.org>; Ethan Jamison - CDPHE <ethan.jamison@state.co.us>; Bol, Kirk <kirk.bol@state.co.us>; Emily Fine - CDPHE <emily.fine@state.co.us>; Barb Becker <bbecker@cbhc.org>; Gebbia, Robert <RGebbia@afsp.org>; Schoenbaum, Michael (NIH/NIMH) [C] <schoenbaumm@mail.nih.gov>; McKeon, Richard (SAMHSA/CMHS) <Richard.McKeon@samhsa.hhs.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Quinlan, Kristen <KQuinlan@edc.org>; Caine, Eric <Eric_Caine@urmc.rochester.edu>; Reed, Jerry <jreed@edc.org>; White, AnnMarie <AnnMarie_White@urmc.rochester.edu>; Conwell, Yeates <Yeates_Conwell@urmc.rochester.edu>; Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC) <dcz0@cdc.gov>
Cc: Betz, Marian <MARIAN.BETZ@ucdenver.edu>; cc: Runyan, Carol <CAROL.RUNYAN@ucdenver.edu>; Allen, Michael <Michael.Allen@ucdenver.edu>; cc: Kyle Brown - GovOffice <kylem.brown@state.co.us>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Wilkins, Natalie J. (CDC/ONDIEH/NCIPC) <hux9@cdc.gov>
Subject: Thank you!

Hello everyone -

Thank you for spending so much of your valuable time with us last week to visit Colorado Springs, Pueblo and Fort Collins. It was a big commitment and I hope you found the meetings to be informative and valuable. I feel like we achieved our goals of learning about each community, starting the process of building partnerships, and informing each community about the CNC. There is a great deal of work in front of us, but this was a great first step.

I have followed-up with the community leaders that helped me organize last week and have shared a link to the data dashboard, the technical package, the transforming communities document, Alex and Jerry's slides, info on the May 2018 RTI, and Kristen's inventory document with each community. I also promised that we'd share meeting notes and next steps and schedule a follow-up call with each community in the next couple of weeks. We will share notes with everyone once they are all complete.

Larimer County partners already developed and sent out a survey to all attendees (you may have received that already), and Emily is helping craft a survey for El Paso and Pueblo. We will share those results as well.

next steps for the CNC steering team:

- Follow-up with local partners

- CDC Foundation Proposal

- ID local leadership groups and key partners in each community

- ID priorities and common vision across counties

- Develop implementation strategies and/or menu of strategies

- Formulate evaluation processes

- Develop plan for fidelity, data collection, reporting

- Develop sustainability plan

Some of these are long-term of course, but it's what I jotted down during our debrief on Wed afternoon.

Let me know what follow-up questions/concerns you have and thank you again to everyone that traveled to each community. Thank you also to everyone that drove. Finally, thanks for getting up so early on Tuesday and Wednesday, and thanks for putting in a 12-hour day on Tuesday!

Jarrod

--

Jarrod Hindman, MS

Deputy Chief

Violence and Injury Prevention-Mental Health Promotion Branch



P 303.692.2539 | F 303.691.7901

4300 Cherry Creek Drive South, Denver CO 80246

jarrod.hindman@state.co.us |

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: 24 May 2018 08:41:09 -0400
To: Robert Gebbia;Belyeu, Avery;Reed, Jerry;Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;Carr, Colleen;Christine Moutier;Melissa Helm
Subject: Re: Transforming Communities Priority 5.23 Leadership Call: Next Steps

6/18 from 3-4 works best for me as well. 6/15 won't work for me.

From: Robert Gebbia
Date: May 24, 2018 at 7:34:34 AM EDT
To: Belyeu, Avery , Reed, Jerry , Mercy, James (CDC/ONDIEH/NCIPC) , Stone, Deborah (CDC/ONDIEH/NCIPC) , Stout, Elly , Carr, Colleen , Christine Moutier , Melissa Helm
Subject: Re: Transforming Communities Priority 5.23 Leadership Call: Next Steps

Avery,

Good call yesterday, thanks.

Best date and time for me is 6/18 from 3 to 4 pm. I'm traveling on 6/15, but should be able to join the call from 2 to 3 pm. The other times won't work for me.

Best regards,
Bob

Sent from my Verizon, Samsung Galaxy smartphone

-------- Original message --------
From: "Belyeu, Avery"
Date: 5/23/18 5:41 PM (GMT-05:00)
To: "Reed, Jerry" , Robert Gebbia , "Mercy, James (CDC/ONDIEH/NCIPC)" , "Stone, Deborah (CDC/ONDIEH/NCIPC)" , "Stout, Elly" , "Carr, Colleen" , Christine Moutier , Melissa Helm
Subject: Transforming Communities Priority 5.23 Leadership Call: Next Steps

Hello All,
It was a pleasure connecting with you all today. Thank you for a generative call.
Below is an outline of next steps:

- Bob, Deb, and Jerry will present the idea of a day- long "academy" to the Colorado National Collaborative and report back to this group regarding the outcome of that conversation.

- This event would focus on presenting currently existing resources including the CDC Technical Package, the Transforming Communities Paper, implementation tools from partner organizations (e.g. SPRC) and as well as relevant data.
- Ongoing work with these partners could provide feedback regarding current tools and help to answer the questions: Are additional tools or resources needed? Do existing tools need to be adapted to better meet the needs of the field?
- Any future "stage 2" efforts in other locations could build on what is learned through this work in Colorado.

- If the decision is to move forward with an "academy" the Secretariat will create an outline of possible structure and assess the potential cost.

As discussed we want to meet again in a few weeks to keep these conversations moving forward. Please review the days and times listed below and respond with your availability:

- Friday, June 15:
  - o 9-10am ET
  - o 2-3pm ET
- Monday, June 18:
  - o 11am-12pm ET
  - o 3pm- 4pm ET

Thank you all for your participation in this call and for helping to identify immediate next steps. I look forward to speaking again in a few weeks.

Kindly,
Avery

Avery Belyeu
National Partnerships Associate
National Action Alliance for Suicide Prevention
The Education Development Center (EDC)
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
(828) 406-4029 (Direct)



From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 24 May 2018 12:59:07 +0000
To: Robert Gebbia;Belyeu, Avery;Reed, Jerry;Mercy, James (CDC/ONDIEH/NCIPC);Stout, Elly;Carr, Colleen;Christine Moutier;Melissa Helm
Subject: RE: Transforming Communities Priority 5.23 Leadership Call: Next Steps

Monday times work best for me. Thanks!
Deb

From: Robert Gebbia
Sent: Thursday, May 24, 2018 7:33 AM
To: Belyeu, Avery ; Reed, Jerry ; Mercy, James (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Stout, Elly ; Carr, Colleen ; Christine Moutier ; Melissa Helm
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To: "Reed, Jerry" <jreed@edc.org>, Robert Gebbia <RGebbia@afsp.org>, "Mercy, James (CDC/ONDIEH/NCIPC)" <jam2@cdc.gov>, "Stone, Deborah (CDC/ONDIEH/NCIPC)" <zaf9@cdc.gov>, "Stout, Elly" <estout@edc.org>, "Carr, Colleen" <ccarr@edc.org>, Christine Moutier <CMoutier@afsp.org>, Melissa Helm <MHelm@afsp.org>
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- Friday, June 15:
  - 9-10am ET

- 2-3pm ET

- Monday, June 18:
  - 11am-12pm ET
  - 3pm- 4pm ET

Thank you all for your participation in this call and for helping to identify immediate next steps. I look forward to speaking again in a few weeks.

Kindly,

Avery

Avery Belyeu
National Partnerships Associate
National Action Alliance for Suicide Prevention
The Education Development Center (EDC)
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
(828) 406-4029 (Direct)



From: Reed, Jerry
Sent: 25 May 2018 01:46:28 +0000
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Robert Gebbia;Belyeu, Avery;Mercy, James (CDC/ONDIEH/NCIPC);Stout, Elly;Carr, Colleen;Christine Moutier;Melissa Helm
Subject: RE: Transforming Communities Priority 5.23 Leadership Call: Next Steps

All proposed times work for me. Thanks.
Jerry

Jerry Reed, PhD, MSW
Senior Vice President for Practice Leadership
Suicide, Violence & Injury Prevention Portfolio Lead
National Action Alliance for Suicide Prevention Executive Committee Member
jreed@edc.org | 202-572-3771 (O) | 202-294-8132 (M) | 202-223-4059 (F)
Education Development Center, Inc.



From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 24, 2018 8:59 AM
To: Robert Gebbia ; Belyeu, Avery ; Reed, Jerry ; Mercy, James (CDC/ONDIEH/NCIPC) ; Stout, Elly ; Carr, Colleen ; Christine Moutier ; Melissa Helm
Subject: RE: Transforming Communities Priority 5.23 Leadership Call: Next Steps

Monday times work best for me. Thanks!
Deb

From: Robert Gebbia <RGebbia@afsp.org>
Sent: Thursday, May 24, 2018 7:33 AM
To: Belyeu, Avery <ABelyeu@edc.org>; Reed, Jerry <jreed@edc.org>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Stout, Elly <estout@edc.org>; Carr, Colleen <ccarr@edc.org>; Christine Moutier <CMoutier@afsp.org>; Melissa Helm <MHelm@afsp.org>
Subject: Re: Transforming Communities Priority 5.23 Leadership Call: Next Steps

Avery,
Good call yesterday, thanks.
Best date and time for me is 6/18 from 3 to 4 pm. I'm traveling on 6/15, but should be able to join the call from 2 to 3 pm. The other times won't work for me.
Best regards,
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Sent from my Verizon, Samsung Galaxy smartphone
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Date: 5/23/18 5:41 PM (GMT-05:00)
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From: Reed, Jerry
Sent: 25 May 2018 01:50:42 +0000
To: Robert Gebbia;Belyeu, Avery;Mercy, James (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;Carr, Colleen;Christine Moutier;Melissa Helm
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To: Reed, Jerry;Robert Gebbia;Mercy, James (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Stout, Elly;Carr, Colleen;Christine Moutier;Melissa Helm
Subject: RE: Transforming Communities Priority 5.23 Leadership Call: Next Steps

Hello All,

Thank you for responding with your availability. I will send out a calendar invitation here shortly.
Jerry, thank you for this note about how to refer to the day-long event. I agree that the way that we refer to this is important and we will make the switch to community collaboration.
Kindly,
Avery

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To: Robert Gebbia ; Belyeu, Avery ; Mercy, James (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Stout, Elly ; Carr, Colleen ; Christine Moutier ; Melissa Helm
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From: Stephanie Coggin
Sent: 28 Jun 2016 13:42:39 +0000
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Alexis O'Brien
Subject: RE: Update Regarding New CDC Report on Suicide by Occupation

Hi Deb – Thank you for the heads up. This is important news. Would this be a report that you could share under embargo by tomorrow? I'd like to give our AFSP team an opportunity to be supportive with a statement or media inquiries. Copying our PR Director Alexis O'Brien too.
Thanks, Stephanie

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T: 212.363.3500 ext. 2027
C: 917.318.3132



From: Zeller, Eileen (SAMHSA/CMHS) [mailto:Eileen.Zeller@samhsa.hhs.gov]
Sent: Tuesday, June 28, 2016 8:53 AM
To: Belyeu, Avery; Pearson, Jane L (NIH/NIMH) [E]; Dan Reidenberg; John Draper; Stout, Elly; Jack Benson; Stephanie Coggin; eneely@reingold.com; Stone, Deborah (CDC/ONDIEH/NCIPC); Carr, Colleen; Weber, Mark (HHS/ASPA); Amy Kulp; steve.mendelsohn@thetrevorproject.org; Chervin, Doryn; Frances Gonzalez; Michael Rosen; Ashley Vactor; Pearson, Jane L (NIH/NIMH) [E]; Holland, Kristin (CDC/ONDIEH/NCIPC); Melnyk, Liliya
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Thank you!
CDC Colleagues: We look forward to reading this.

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To: Pearson, Jane L (NIH/NIMH) [E]; Zeller, Eileen (SAMHSA/CMHS); Dan Reidenberg; John Draper; Stout, Elly; Jack Benson; Stephanie Coggin; eneely@reingold.com; Stone, Deborah (CDC/ONDIEH/NCIPC); Carr, Colleen; Weber, Mark (HHS/ASPA); Amy Kulp; steve.mendelsohn@thetrevorproject.org; Chervin, Doryn; Frances Gonzalez; Michael Rosen; Ashley Vactor; Pearson, Jane L (NIH/NIMH) [E]; Holland, Kristin (CDC/ONDIEH/NCIPC); Melnyk, Liliya
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My Best,
Avery

In the spirit of continued coordination and information sharing, I wanted to let you know in advance about an upcoming article in MMWR, which will be titled **Suicide by Occupation – 17 States, 2012**. This article will be released on Thursday, June 30, 2016 at 1 pm ET. The data have been pulled from the National Violent Death Reporting System, and the report analyzes suicide deaths for those over the age of 16 by sex and occupation.
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I appreciate you keeping this information about this article within your organization until the report is officially released (Thursday, June 30, 2016 at 1 pm ET), but hope you will consider joining the conversation after the release date by:

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- Sending questions about the report to dvpinquiries@cdc.gov

Thank you for all of your work to prevent suicides and help people live their lives to their fullest potential!

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From: Bartholow, Brad (CDC/ONDIEH/NCIPC)
Sent: 28 Jun 2016 14:45:32 -0400
To: Stephanie Coggin
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC);McIntosh, Wendy LiKamWa (CDC/ONDIEH/NCIPC)
Subject: RE: Update Regarding New CDC Report on Suicide by Occupation

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Thanks very much for your interest and all that AFSP does to prevent suicide and support mental health!
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Brad Bartholow, Ph.D.
Team Lead: Youth Violence, Suicide, and Elder Maltreatment Team
Research & Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
4770 Buford Highway, MS F-64
Atlanta, GA. 30341
Email: bnb1@cdc.gov
Office phone: 770-488-4278
Mobile phone: 571-420-8543

From: Stephanie Coggin [mailto:SCoggin@afsp.org]
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Thank you so much! I think it would be helpful so you have others able to support you right when the report is released.
Thanks, Stephanie

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Subject: RE: Update Regarding New CDC Report on Suicide by Occupation

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Thanks,
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To: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Subject: FW: Update Regarding New CDC Report on Suicide by Occupation

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From: Stephanie Coggin
Sent: Tuesday, June 28, 2016 9:43 AM
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Cc: Alexis O'Brien
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From: Bartholow, Brad (CDC/ONDIEH/NCIPC) [mailto:bnb1@cdc.gov]
Sent: Tuesday, June 28, 2016 2:46 PM
To: Stephanie Coggin
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Sent: Tuesday, June 28, 2016 10:31 AM
To: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Subject: RE: Update Regarding New CDC Report on Suicide by Occupation

Thanks Brad, I appreciate it.
Thanks, Stephanie

Stephanie Coggin
VP, Communications & Marketing
American Foundation for Suicide Prevention
120 Wall Street |29th floor | New York, NY 10005
T: 212.363.3500 ext. 2027
C: 917.318.3132



From: Bartholow, Brad (CDC/ONDIEH/NCIPC) [mailto:bnb1@cdc.gov]
Sent: Tuesday, June 28, 2016 10:22 AM
To: Stephanie Coggin
Subject: RE: Update Regarding New CDC Report on Suicide by Occupation

Good morning Stephanie,
I'll check with our Communications and Policy Teams. I'll let you know.

Thanks,
Brad

From: Stephanie Coggin [mailto:SCoggin@afsp.org]
Sent: Tuesday, June 28, 2016 9:49 AM
To: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Subject: FW: Update Regarding New CDC Report on Suicide by Occupation

Hi Brad – With Deb out through Thursday, is this something that you could help us with?
Thanks, Stephanie

Stephanie Coggin
VP, Communications & Marketing
American Foundation for Suicide Prevention
120 Wall Street |29th floor | New York, NY 10005
T: 212.363.3500 ext. 2027
C: 917.318.3132



From: Stephanie Coggin
Sent: Tuesday, June 28, 2016 9:43 AM
To: Deborah Stone
Cc: Alexis O'Brien
Subject: RE: Update Regarding New CDC Report on Suicide by Occupation

Hi Deb – Thank you for the heads up. This is important news. Would this be a report that you could share under embargo by tomorrow? I'd like to give our AFSP team an opportunity to be supportive with a statement or media inquiries. Copying our PR Director Alexis O'Brien too.
Thanks, Stephanie

Stephanie Coggin
VP, Communications & Marketing
American Foundation for Suicide Prevention
120 Wall Street |29th floor | New York, NY 10005
T: 212.363.3500 ext. 2027
C: 917.318.3132



From: Zeller, Eileen (SAMHSA/CMHS) [mailto:Eileen.Zeller@samhsa.hhs.gov]
Sent: Tuesday, June 28, 2016 8:53 AM
To: Belyeu, Avery; Pearson, Jane L (NIH/NIMH) [E]; Dan Reidenberg; John Draper; Stout, Elly; Jack Benson; Stephanie Coggin; eneely@reingold.com; Stone, Deborah (CDC/ONDIEH/NCIPC); Carr, Colleen; Weber, Mark (HHS/ASPA); Amy Kulp; steve.mendelsohn@thetrevorproject.org; Chervin, Doryn; Frances Gonzalez; Michael

Rosen; Ashley Vactor; Pearson, Jane L (NIH/NIMH) [E]; Holland, Kristin (CDC/ONDIEH/NCIPC); Melnyk, Liliya
Subject: RE: Update Regarding New CDC Report on Suicide by Occupation

Thank you!

CDC Colleagues: We look forward to reading this.

From: Belyeu, Avery [mailto:ABelyeu@edc.org]
Sent: Monday, June 27, 2016 5:49 PM
To: Pearson, Jane L (NIH/NIMH) [E]; Zeller, Eileen (SAMHSA/CMHS); Dan Reidenberg; John Draper; Stout, Elly; Jack Benson; Stephanie Coggin; eneely@reingold.com; Stone, Deborah (CDC/ONDIEH/NCIPC); Carr, Colleen; Weber, Mark (HHS/ASPA); Amy Kulp; steve.mendelsohn@thetrevorproject.org; Chervin, Doryn; Frances Gonzalez; Michael Rosen; Ashley Vactor; Pearson, Jane L (NIH/NIMH) [E]; Holland, Kristin (CDC/ONDIEH/NCIPC); Melnyk, Liliya
Subject: Update Regarding New CDC Report on Suicide by Occupation

Dear Media Messaging Workgroup,

On the Media Messaging Workgroup call on Monday, June 20th, Deb Stone shared information about an upcoming article in MMWR. Please see the information below regarding the upcoming release of the article on June, 30th, including how to join the conversation after the release date and who to contact for more information.

My Best,
Avery

In the spirit of continued coordination and information sharing, I wanted to let you know in advance about an upcoming article in MMWR, which will be titled **Suicide by Occupation – 17 States, 2012**. This article will be released on Thursday, June 30, 2016 at 1 pm ET. The data have been pulled from the National Violent Death Reporting System, and the report analyzes suicide deaths for those over the age of 16 by sex and occupation.

The key findings from the report (which I unfortunately can't share outside the agency yet) will include the highest rates of suicide by occupational categories. These findings can help employers and suicide prevention professionals know who may need to be reached by suicide prevention activities.

I appreciate you keeping this information about this article within your organization until the report is officially released (Thursday, June 30, 2016 at 1 pm ET), but hope you will consider joining the conversation after the release date by:

- Sharing a message on social media:
  - New CDC report analyzes highest suicide rate by occupation and sex. #VetoViolence
  - Results from new CDC report can help target suicide prevention work to certain occupations. #VetoViolence
- Forwarding the upcoming partner announcement through email
- Sending questions about the report to dvpinquiries@cdc.gov

Thank you for all of your work to prevent suicides and help people live their lives to their fullest potential!

Avery Belyeu
National Partnerships Associate
National Action Alliance for Suicide Prevention
The Education Development Center (EDC)
1025 Thomas Jefferson St, St.700W
Washington, DC 20007
(828) 406-4029 (Direct)


SPRC
EDC
Learning
transforms
lives.

From: Gutierrez, Peter M.
Sent: 30 Nov 2017 00:19:37 +0000
To: Hindman - CDPHE, Jarrod;Sarah Brummett - CDPHE;Brian Turner;Ethan Jamison - CDPHE;Bol, Kirk;Emily Fine - CDPHE;Barb Becker;Gebbia, Robert;Schoenbaum, Michael (NIH/NIMH) [C];McKeon, Richard (SAMHSA/CMHS);Crosby, Alexander (CDC/ONDIEH/NCIPC);Quinlan, Kristen;Caine, Eric D. MD;Reed, Jerry;White, AnnMarie;Conwell, Yeates;Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Cc: Kyle Brown - GovOffice;Betz, Marian;Allen, Michael;Runyan, Carol
Subject: RE: [EXTERNAL] Detailed agendas

Thanks, Jarrod, the agendas look fine to me. Hope the larger group in Larimer County doesn't complicate things too much for us, but it's great there is so much interest!
Cheers,
Pete
Peter M. Gutierrez, Ph.D.
Clinical/Research Psychologist
ROCKY MOUNTAIN MIRECC
Office: 303-329-4408 ext 301
https://www.mirecc.va.gov/visn19/
Professor
University of Colorado School of Medicine, Department of Psychiatry
http://www.ucdenver.edu/academics/colleges/medicalschool/departments/psychiatry/Pages/PsychiatryWelcome.aspx
From: Hindman - CDPHE, Jarrod [mailto:jarrod.hindman@state.co.us]
Sent: Wednesday, November 29, 2017 4:32 PM
To: Sarah Brummett - CDPHE ; Gutierrez, Peter M. ; Brian Turner ; Ethan Jamison - CDPHE ; Bol, Kirk ; Emily Fine - CDPHE ; Barb Becker ; Gebbia, Robert ; Schoenbaum, Michael (NIH/NIMH) [C] ; McKeon, Richard (SAMHSA/CMHS) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Quinlan, Kristen ; Caine, Eric D. MD ; Reed, Jerry ; White, AnnMarie ; Conwell, Yeates ; Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Cc: Kyle Brown - GovOffice ; Betz, Marian ; Allen, Michael ; Runyan, Carol
Subject: [EXTERNAL] Detailed agendas
Attached. Let me know what I've missed and/or what needs to be amended.
Alex / Shakiyla - Can one of you present on the Technical Package?
Jerry / Bob - Can one of you present on the Transforming Communities doc?
Ethan / Kirk - note the data presentation section and let me know if anything needs to be tweaked.
FYI. . . I just sent these to local partner leaders as well, so there may be some adjustments. I'll keep you posted if so.
Thank you.
Jarrod

--

Jarrod Hindman, MS

Deputy Chief

Violence and Injury Prevention-Mental Health Promotion Branch



P 303.692.2539 | F 303.691.7901

4300 Cherry Creek Drive South, Denver CO 80246

jarrod.hindman@state.co.us |

Issue	Keywords	Terms from Original request to cull NUIX output	Date Range	To:/From:	Mail Boxes Searched
3[1]	("lethal means" AND gun) AND (dickey OR "gun control")	(Vital Signs AND Suicide) OR (MMWR AND Suicide) Or (Suicide AND Dickey)	01/01/2016 - present	N/A	Ann Schuchat (2), Alexander Crosby, Linda Dahlberg, Katherine Fowler, Kristin Holland, Asha Ivey-Stephenson, Scott Kegler, Thomas Simon, Deborah Stone, Keming Yuan
4	N/A	Dickey or MMWR (note it seems pointless to use "suicide for AFSP! Or "Technical Package"	01/01/2016 - present	AFSP.org	Alexander Crosby, Katherine Fowler, Kristin Holland, Asha Ivey-Stephenson, Scott Kegler, Thomas Simon, Deborah Stone, Keming Yuan
5	N/A	NA	01/01/2016 - present	NRA.org	All CDC employees (4 separate queries)
6	suicide AND ("talking point" OR "TP" OR "media interview" OR telebriefing)	(Vital Signs AND Suicide) OR (MMWR AND Suicide) OR (Suicide and Technical Package) OR Dickey	01/01/2018 - present	N/A	Ann Schuchat (2), Deborah Stone

From: National Rifle Association
Sent: 2 Apr 2018 15:15:02 -0600
To: Duncan, James Brad (CDC/OCOO/OSSAM)
Subject: Exclusively For James - NRA Member

VIEW IN BROWSE

NRA | NATIONAL RIFLE ASSOCIATION MEMBERSHIP



Dear ,

Every time NRA has a fight, you dedicate your membership dues and donations to our cause.

YOU are the reason why NRA wins and why we have our guns today.

That's why I want to thank you by giving you membership benefits that are worth far more than you pay in dues.

ACCESS MY BENEFITS

To tap the fantastic value of your NRA membership benefits, visit our website, NRA.org/5-StarBenefits today.

Thanks again for your friendship and support of NRA.

Yours In Freedom,



Wayne LaPierre
Executive Vice President

National Rifle Association * 11250 Waples Mill Rd * Fairfax, VA. 22030

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Thank you.

From: National Rifle Association
Sent: 11 May 2018 10:29:51 -0600
To: Duncan, James Brad (CDC/OCOO/OSSAM)
Subject: Lt. Colonel Oliver North Poised to Become NRA President

VIEW IN BROWSER

NRA | NATIONAL RIFLE ASSOCIATION

Lt. Colonel Oliver North Poised To Become NRA President



"Most exciting news for NRA members since Charlton Heston Became President of Our Association," Wayne

LaPierre said.

(DALLAS, TX) – Lt. Colonel Oliver North, USMC (Ret.) will become President of the National Rifle Association of America within a few weeks, a process the NRA Board of Directors initiated this morning.

“This is the most exciting news for our members since Charlton Heston became President of our Association,” said NRA Executive Vice President and CEO Wayne LaPierre. “Oliver North is a legendary warrior for American freedom, a gifted communicator and skilled leader. In these times, I can think of no one better suited to serve as our President.”

North said he was eager to take on this new role as soon as his business affairs were put in order. North is retiring from Fox News, effective immediately. “I am honored to have been selected by the NRA Board to soon serve as this great organization’s President,” North said. “I appreciate the board initiating a process that affords me a few weeks to set my affairs in order, and I am eager to hit the ground running as the new NRA President.”

The NRA Board acted quickly to begin the process for North to become President, after former NRA President Pete Brownell announced this morning that, in order to devote his full time and energy to his family business, he had decided not to seek election to a second term. In his letter to the Board, Brownell wholeheartedly endorsed North for President.

“Discussing this with Wayne LaPierre,” Brownell said in the letter, “he suggested we reach out to a warrior amongst our board members, Lieutenant Colonel Oliver North, to succeed me. Wayne and I feel that in these extraordinary times, a leader with his history as a communicator and resolute defender of the Second Amendment is precisely what the NRA needs. After consulting with NRA-ILA Executive Director Chris Cox, First Vice President Childress and Second Vice President Meadows, I can report there is extraordinary support for Col. North.”

“Pete has served the NRA with great courage and distinction,” LaPierre said. “I am grateful that he joined me in enthusiastically recommending Oliver North to the Board of Directors.”

After the announcement, NRA First Vice President Richard Childress informed the board that he had multiple commitments in the next several weeks and was unable to be immediately available to serve as interim President. The Board then selected Second Vice President Carolyn Meadows to serve as its interim President. Meadows will step aside in a few weeks, when Lt. Colonel North is prepared to take on his new role as NRA President.

LaPierre congratulated the NRA Board for its action. “The board acted quickly and with great vision,” LaPierre said. “Oliver North is, hands down, the absolute best choice to lead our NRA Board, to fully engage with our members, and to

unflinchingly stand and fight for the great freedoms he has defended his entire life."

"Oliver North is a true hero and warrior for freedom," LaPierre said, "and NRA members are proud to stand with him."

National Rifle Association of America • 11250 Waples Mill Rd • Fairfax, VA. 22030

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Thank you

From: National Rifle Association
Sent: 23 Apr 2018 11:31:27 -0600
To: Duncan, James Brad (CDC/OCOO/OSSAM)
Subject: NRA Board of Directors Loses Beloved Member

VIEW IN BROWSER

NRA | NATIONAL RIFLE ASSOCIATION

R. Lee Ermey Passes Away at 74



By Philip Schreier, Senior Curator, NRA Museums - Monday, April 16, 2018

The NRA Board of Directors lost one of its beloved members on Sunday, April 15, 2018 when R. Lee Ermey of Palmdale, Calif., passed away from complications of pneumonia at the age of 74.

Known to millions of fans as "Gunny," Ermey was a native of Emporia, Kansas. He enlisted in the United States Marine Corps at the age of 17 and served for 11 years, 14 months of which were spent in Vietnam.

It was Stanley Kubrick's 1987 film, Full Metal Jacket, that earned him lasting fame and the sobriquet "Gunny" for his stunning performance as Marine Corps Drill Instructor Gunnery Sergeant Hartman. Although he was medically discharged from the Marine Corps as a Staff Sergeant, he was recalled from retirement and officially promoted to Gunnery Sergeant and

then immediately retired at the rank for which everyone came to know and love him.

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Thank you

From: National Rifle Association Member Support
Sent: 4 Apr 2016 08:35:55 -0600
To: Holcomb, Daniel (Dan) (CDC/ONDIEH/NCIPC)
Subject: The gift you selected with your membership...

NRA | NATIONAL RIFLE ASSOCIATION

Dan Holcomb,

From all of us at NRA, I want to send my most sincere thanks for your decision to join our NRA family and our fight for freedom.

Over the past few weeks, we've heard from patriots and leaders like you from across the nation, all committed to one single goal to protect our Second Amendment rights and all our freedoms in the most important election our nation has ever faced.

In fact, so many new members have joined our ranks in the past few days that we've run short of the bag that we promised when you joined. Don't worry more are on the way! And I know you'll enjoy this symbol of your leadership and commitment for years to come. But in the meantime, it may take a few weeks to get your bag to you, and I ask for your patience.

Your decision to join NRA has given me new hope and encouragement that we will win this election and that we will keep our guns and all the precious freedoms that our Constitution guarantees.

It's a tremendous honor to have you on our team. I look forward to sending your bag just as soon as our new shipment arrives, and I look forward to working closely with you this year.

Yours in Freedom,

Wayne LaPierre
Executive Vice President
National Rifle Association of America

National Rifle Association of America
11250 Waples Mill Road, Fairfax, VA 22030, United States
Contact Us
Click Here To Unsubscribe

From: noreply-instructoradmin@nra.org
Sent: 10 Apr 2017 11:03:08 -0400
To: Sarge, Jonathan (CDC/OCOO/OSSAM) (CTR)
Subject: Your Certificate / Id Card - Electronic copy
Attachments: JONATHAN E. SARGE-Range Safety Officer.pdf
Importance: High

THE NATIONAL RIFLE ASSOCIATION OF AMERICA

CERTIFIES THAT

JONATHAN E. SARGE

Has successfully met the requirements established by the National Rifle Association of America and is hereby designated an

NRA RANGE SAFETY OFFICER

RANGE SAFETY OFFICER

NRA

JOHN C. FRAZER, SECRETARY
NATIONAL RIFLE ASSOCIATION

Valid through: 5/31/2018

From: noreply-instructoradmin@nra.org
Sent: 10 Apr 2017 11:02:14 -0400
To: Sarge, Jonathan (CDC/OCOO/OSSAM) (CTR)
Subject: Your Certificate / Id Card - Electronic copy
Attachments: JONATHAN E. SARGE-Instructor.pdf
Importance: High

THE NATIONAL RIFLE ASSOCIATION OF AMERICA

CERTIFIES THAT

JONATHAN E. SARGE

Has successfully met the requirements established by the National Rifle Association of America and is hereby designated an

NRA INSTRUCTOR

and is authorized to teach the following basic courses:

Certified Pistol * Personal Protection In The Home * Personal Protection Outside The Home

INSTRUCTOR

NRA

JOHN C. FRAZER, SECRETARY
NATIONAL RIFLE ASSOCIATION

Valid through: 5/31/2018

From: noreply-instructoradmin@nra.org
Sent: 12 Sep 2016 19:08:59 -0400
To: Wallace, Joshua (CDC/OCOO/OSSAM) (CTR)
Subject: Your Certificate / Id Card - Electronic copy
Attachments: JOSHUA ANDREW WALLACE-Instructor.pdf
Importance: High

THE NATIONAL RIFLE ASSOCIATION OF AMERICA

CERTIFIES THAT

JOSHUA ANDREW WALLACE

Has successfully met the requirements established by the National Rifle Association of America and is hereby designated an

NRA INSTRUCTOR

and is authorized to teach the following basic courses:

Certified Pistol * Certified Rifle * Certified Shotgun

INSTRUCTOR

NRA

JOHN C. FRAZER, SECRETARY
NATIONAL RIFLE ASSOCIATION

Valid through: 9/30/2018

From: noreply-instructoradmin@nra.org
Sent: 12 Sep 2016 19:08:14 -0400
To: Wallace, Joshua (CDC/OCOO/OSSAM) (CTR)
Subject: Your Certificate / Id Card - Electronic copy
Attachments: JOSHUA ANDREW WALLACE-IdCard.pdf
Importance: High

National Rifle Association Credentials

JOSHUA ANDREW WALLACE
Instructor

Certified Pistol * Certified Rifle * Certified Shotgun

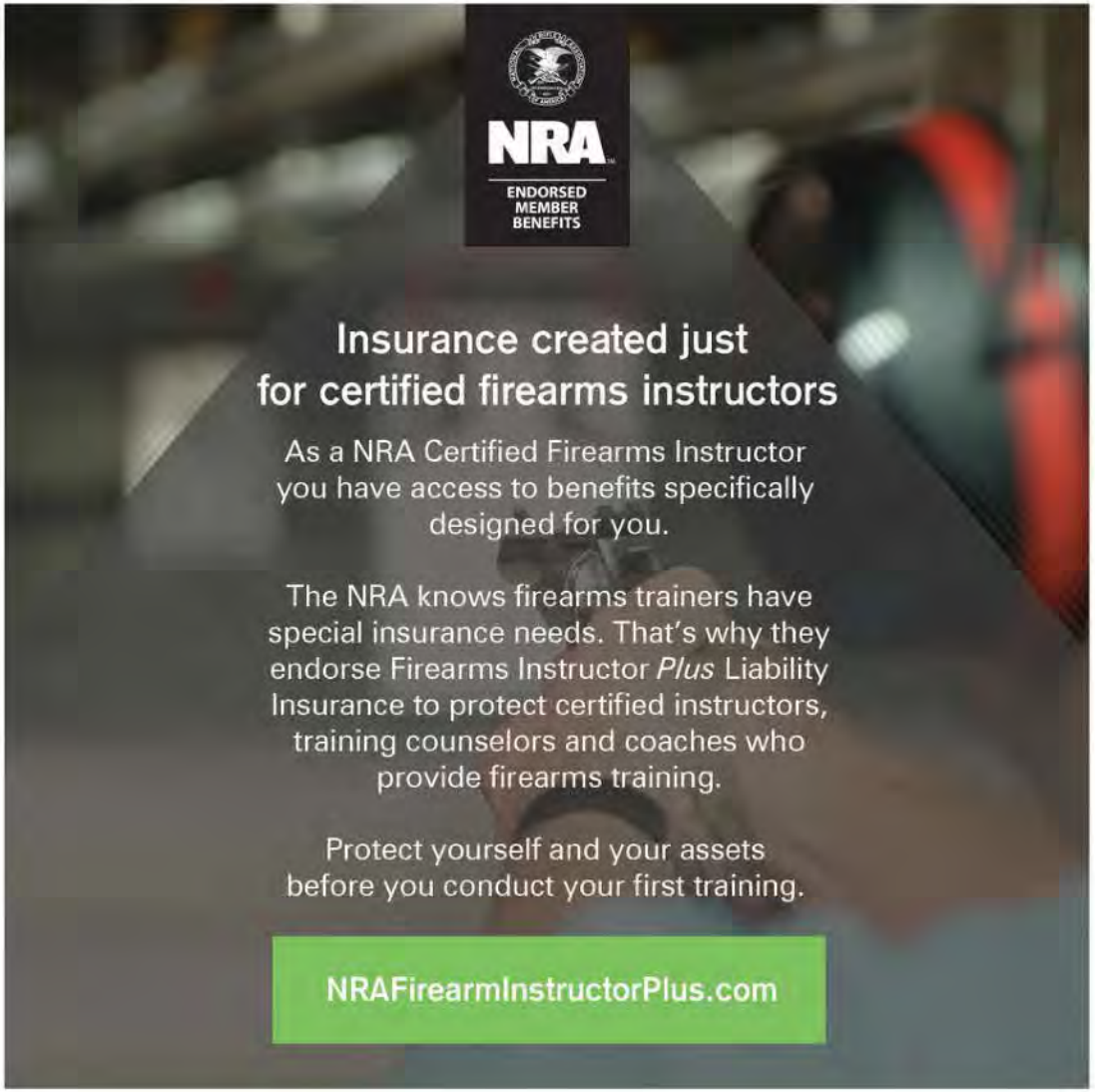
NRA # 101000184246335
Expires: 09/30/2018

John C. Frazer, Secretary
Not valid for conducting NRA Law Enforcement or NRA Security Officer Training Courses.

Possession of this card carries responsibility for representing the whole shooting fraternity to those with whom you deal as well as to the community as a whole. Much of what people think of guns, shooting and shooters depends on you. Good luck!

To contact Education & Training

Call: (703)267-1500
Email: nrainstructors@nrahq.org
trainingcounselor@nrahq.org



From: noreply-instructoradmin@nra.org
Sent: 12 Sep 2016 19:08:41 -0400
To: Wallace, Joshua (CDC/OCOO/OSSAM) (CTR)
Subject: Your Certificate / Id Card - Electronic copy
Attachments: JOSHUA ANDREW WALLACE-IdCard.pdf
Importance: High

National Rifle Association Credentials

JOSHUA ANDREW WALLACE
Instructor

Certified Pistol * Certified Rifle * Certified Shotgun

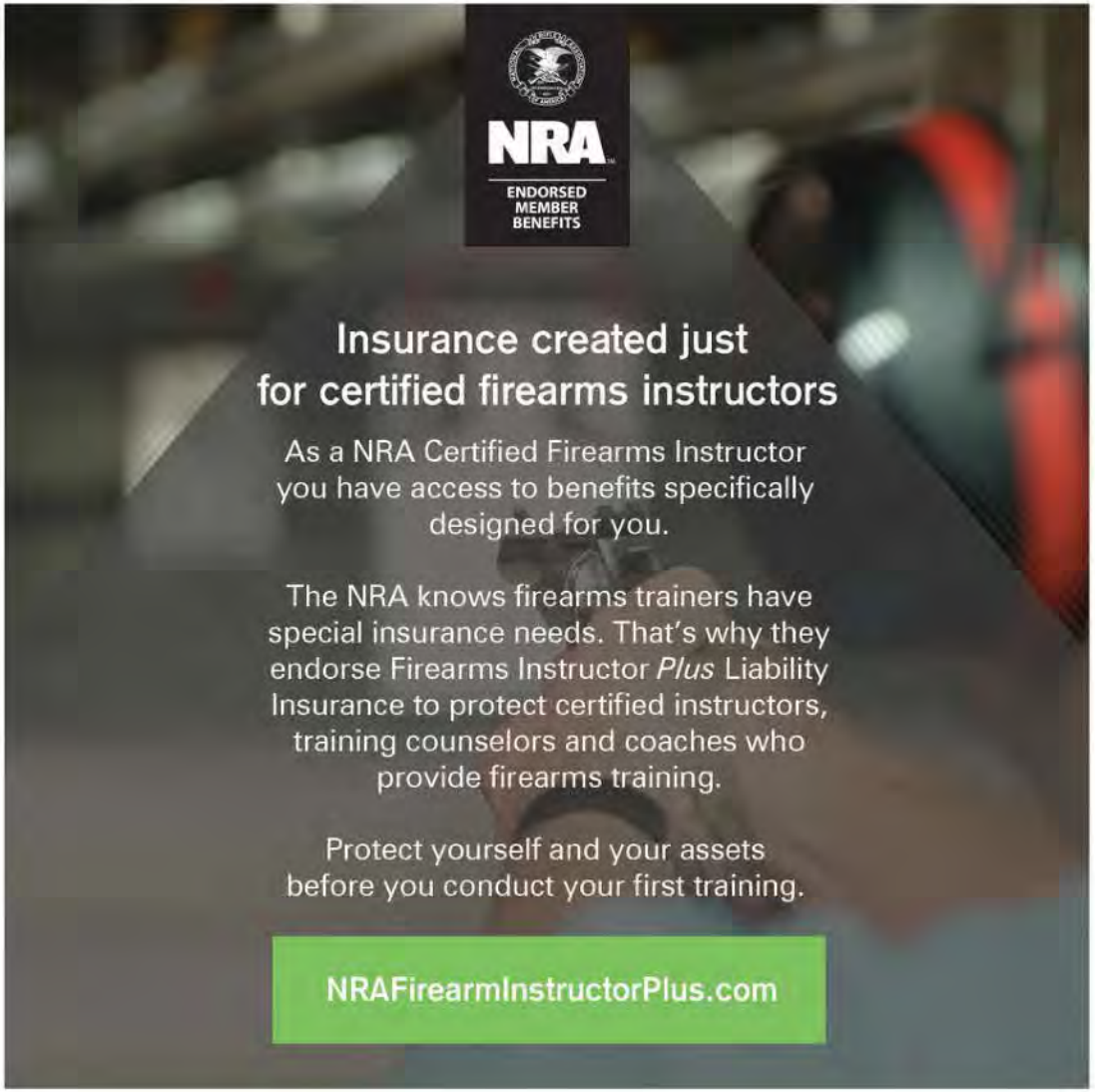
NRA # 101000184246335
Expires: 09/30/2018

John C. Frazer, Secretary
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Call: (703)267-1500
Email: nrainstructors@nrahq.org
trainingcounselor@nrahq.org



From: noreply-instructoradmin@nra.org
Sent: 10 Apr 2017 11:03:40 -0400
To: Sarge, Jonathan (CDC/OCOO/OSSAM) (CTR)
Subject: Your Certificate / Id Card - Electronic copy
Attachments: JONATHAN E. SARGE-IdCard.pdf
Importance: High

National Rifle Association Credentials

JONATHAN E. SARGE
Range Safety Officer
Instructor

Certified Pistol * Personal Protection In The Home * Personal Protection Outside The Home

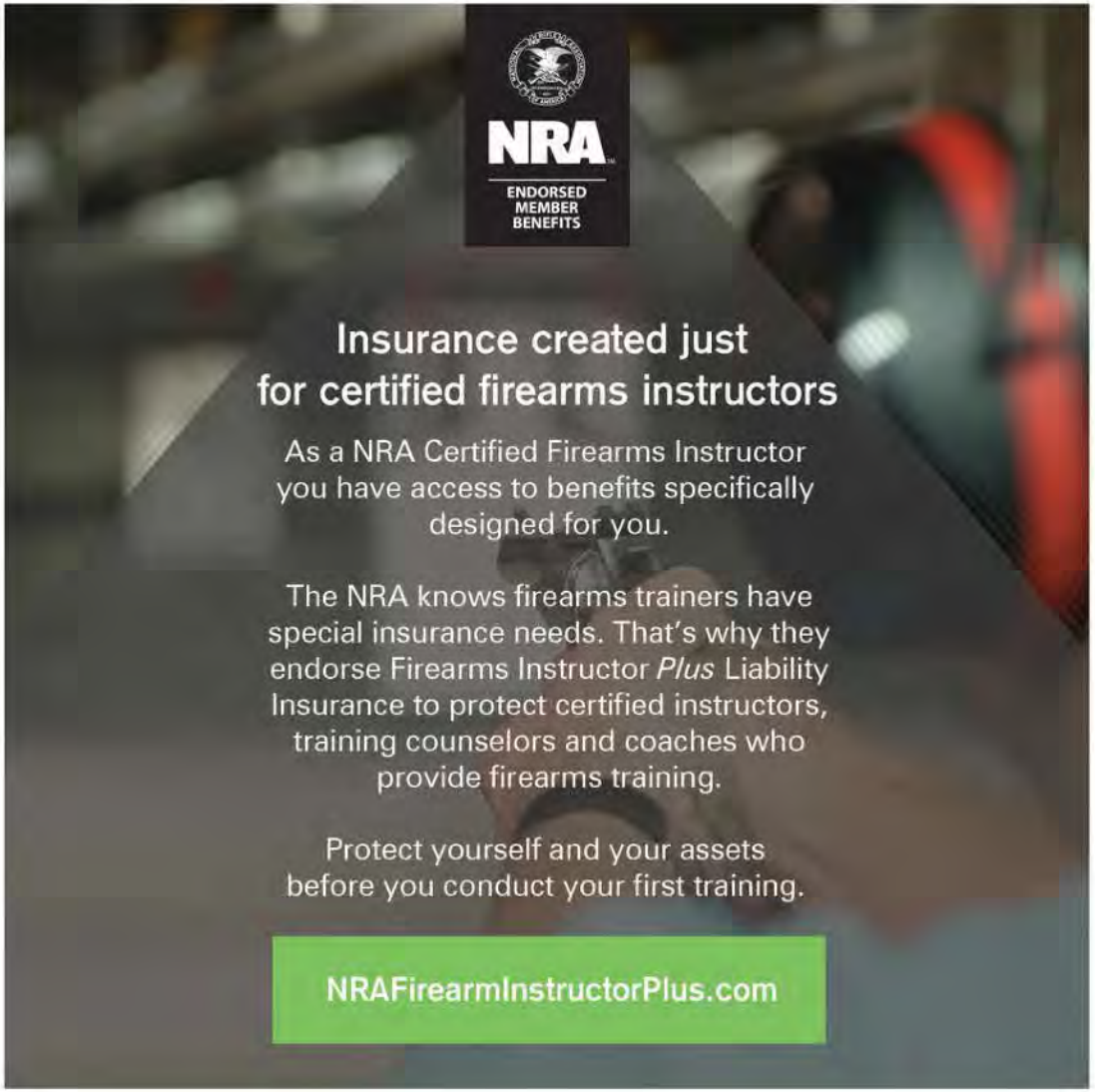
John C. Frazer, Secretary
Not valid for conducting NRA Law Enforcement or NRA Security Officer Training Courses.

NRA # 193757147
Expires: 05/31/2018

Possession of this card carries responsibility for representing the whole shooting fraternity to those with whom you deal as well as to the community as a whole. Much of what people think of guns, shooting and shooters depends on you. Good luck!

To contact Education & Training

Call: (703)267-1500
Email: nrainstructors@nrahq.org
trainingcounselor@nrahq.org



From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 16 Jul 2018 09:16:29 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: A few more to approach summaries to review
Attachments: SUI_Postvention - for SME review.docx, SUI_Safe Reporting and Messaging About Suicide - for SME review.docx

Hello –
Here are two more summaries to review over the next few days. For all of these, no need to do a thorough review – just a quick scan to make sure there are no glaring mistakes or things missing that should definitely be included.
Let me know if you have any questions. Thanks for your help!
Linda

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Friday, July 13, 2018 3:07 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: For Review by COB 8/17: suicide approach summaries for the implementation guidance

Hello,
We are in the home stretch of completing the implementation guidance for the TP's. One component of the guidance pertains to the specific approaches in the technical packages. We are down to the last 8 summaries – 7 of them are specific to the suicide TP. We put these on hold until after the Vital Signs – for obvious reasons!
Attached are 3 short ones for your review.
Lindsey is hoping to get this last batch into clearance ASAP – we are up against a contract deadline with Banyan. If you could review and send any comments/suggestions on the three attached by Tuesday COB, I'll incorporate your changes and get them ready for clearance.
The other ones that we need to finalize include:

- Postvention
- Safer suicide care through system change
- Treatment for people at risk of suicide
- Treatment for victims/survivors (which includes content across the technical packages)

Please let me know if you have any questions.
Thanks in advance for your help!
Linda

Postvention

Postvention approaches are implemented after a suicide has taken place and are intended to provide bereavement support for surviving family members, friends, and other close contacts. Postvention includes debriefing sessions, counseling, support groups, and other activities to facilitate healing. People who have lost a friend/peer, family member, co-worker or someone else close to them to suicide are at increased risk for suicide. Care and attention to the bereaved is important for helping reduce this risk.

Strategy

- **Lessen Harms and Prevent Future Risk** (Suicide)

Key Objectives	• Facilitate healing and promote healthy recovery of individuals, families, and communities bereaved by suicide • Prevent suicide among surviving friends, family, and/or community members
Implementation Considerations	• Postvention may be delivered in a variety of settings (e.g., schools, workplaces, community) • Procedures for responding effectively to suicide and connecting survivors to community services and resources should be developed and in place prior to a death by suicide • A multidisciplinary team comprised of mental health professionals, people who have previous experience surviving a suicide loss, and others involved in crisis response activities can help ensure resources are appropriately identified and in place to support survivors • Postvention plans should be flexible to address a variety of circumstances and take into account both shorter- and longer-term needs
Sector Engagement	• Public health • Education • Business and Labor • Healthcare • Government • Community organizations
Example Outcomes	• Reductions in ○ survivors' guilt, feelings of depression, and distress ○ contagion effects related to suicide ○ suicide attempts ○ suicidal ideation
Additional Resources	• Postvention (Suicide Prevention Resource Center) - http://www.sprc.org/comprehensive-approach/postvention • Postvention for College Campuses (Higher Education Mental Health Alliance) - http://hemha.org/postvention_guide.pdf • Postvention Guide – Alaska Suicide Prevention Plan - http://dhss.alaska.gov/dbh/Documents/Prevention/docs/POSTVENTION%20GUIDE%20V5.pdf

Example Programs/Practices/Policies:

- StandBy Response Service (Suicide)

Example Programs

StandBy Response Service (Suicide)

Description: StandBy Response Service is a suicide bereavement support service. The service provides clients with face-to-face outreach and telephone support provided by a professional crisis response team. A site coordinator then develops a customized case management plan, referring clients to other existing community services matched to their needs. The program also includes community education and activities with local community groups, businesses, and other organizations.

Specific Populations/Settings	Key Partners	Considerations
• Population(s): Persons bereaved by a recent or past suicide • Setting(s): Community	• Health care • Mental health providers • Community organizations • Public health agencies	• Services are available 24/7 and may be delivered in-person or by phone • Consultation and support is available to coordinators at Standby Response sites • Program cost information is not available

Additional Information

- StandBy Support After Suicide Program Site - http://standbysupport.com.au/

Safe Reporting and Messaging About Suicide

The manner in which information on a recent suicide is communicated to the public can heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion. This approach promotes prevention messaging and reporting on suicide in a way that reduces the possibility of suicide contagion, encourages help-seeking, and promotes evidence-based actions that can help prevent suicide.

Strategy

- **Lessen Harms and Prevent Future Risk** (Suicide)

Key Objectives	• Increase awareness and adherence to guidelines for reporting on suicide • Reduce the likelihood of suicide contagion • Promote positive prevention messages
Implementation Considerations	• Present accurate information about suicide rates and trends • Use suicide prevention experts to provide accurate information on suicide risk factors, warning signs, and prevention • Avoid sensationalizing suicide or referring to suicide as "successful" or "unsuccessful" or a "failed attempt" • Avoid conveying details around the method used in the suicide • Provide information in a way that avoids attributing suicide to a single cause • Incorporate prevention messages and actions that can help prevent suicide • Promote evidence-based solutions and prevention success stories • Use stories of hope and resilience • Encourage help-seeking by Incorporating information on local resources and support
Sector Engagement	• Public health • Media • Education • Government • Community organizations
Example Outcomes	• Reductions in ○ rates of suicide ○ contagion effects related to suicide • Increases in protective factors • Improvements in reporting following suicide
Additional Resources	• Recommendations for Reporting on Suicide - http://reportingonsuicide.org/ • Suicide Prevention Resource Center - http://www.sprc.org/keys-success/safe-messaging-reporting

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 26 Mar 2018 13:06:17 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC)
Subject: Attachments for 10 am
Attachments: MMWR WG meeting 3.26.18.docx, Suicide Vital Signs MMWR Text 3.23.18 v3.2 SK TS ds.docx, Suicide Vital Signs MMWR Text 3.19.18 v3 (pre-clearance)_CF_EB MRC.docx

Hi Everyone,
Attaching the most recent version of the MMWR with Scott and Tom's edits incorporated. I've left in tracked changes the final things needing discussion.
Also including the pre-clearance version with reviewer suggestions and a handout.
Thanks,
Deb

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3/26/18

Vital Signs Suicide MMWR WG Meeting

Purpose: to discuss revisions based on pre-clearance draft feedback prior to clearance submission

Items to discuss in article text

- Reactions to edits generally
- Title of MMWR –for authorship statements
- Deletion of p<.01 everywhere
- *Revision to the definition of MHP
- *Reporting on treatment (mental health and substance abuse)
- Reporting of results, % vs aOR
- Discussion, first paragraph and clarification on substance abuse disorders
- Other suggested changes

Table comments:

Table 1:

Wonder if in a revised title or footnote if it needs to be revised to reflect this also includes District of Columbia.---**Suggest not changing**

Suggest being clear on what these period, similar to how done in another footnote. Changing to 1999-2001 and 2014-2016 to represent first and last reporting periods, respectively.

Table 2

- is an additional footnote needed on total or on the categories below to reflect why some don't add up to the overall total (e.g., age, incident type)
- "single suicide" made me wonder about simultaneous or related suicides by more than one person, especially given this is available in NVDRS. Wonder if need another category for multiple, related suicides or if the suicide category should be renamed

Table 3

Typo in "release". Is it possible to also describe what recent means? Past two week or is this quite variable? Given the broad audience of MMWR, can this be put into more simple terms?

Rev 3.26.18 v3.2

Short title: Increasing Trends in State Suicide Rates and Contributing Circumstances among people ≥10 years

Deborah M. Stone, ScD;[1] Thomas R. Simon PhD;[1] Katherine A. Fowler, PhD;[1] Scott R. Kegler, PhD;[2] Keming Yuan, MS;[1] Kristin M. Holland, PhD;[1] Asha Z. Ivey-Stephenson, PhD;[1] Alex E. Crosby, MD[1]

Structured abstract (245/250 words—this word count is not included in the 1800 max for the remainder)

Background: Suicide rates have risen nearly 30% since 1999. Mental health problems (MHP) are just one factor contributing to suicide. Examining state-level trends in suicide and other contributing circumstances can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among people aged ≥10 years, by state and sex, across six consecutive three-year periods (1999-2016), were assessed using data from the National Vital Statistics System for 50 states and Washington, D.C (D.C.). Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known MHP.

Results: From 1999-2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases of 30% or more. Rates increased significantly among males and females, in 34 and 43 states, respectively. Over half (54.0%) of decedents did *not* have a known MHP. Among decedents with circumstance information, those without known MHP were more likely (all $p \leq .01$) than those with a MHP to have relationship problems/loss (45.1% vs 39.6%), life stressors/loss (54.2% vs 49.7%) and recent/impending crises (32.9% vs 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states from 1999-2016. Various circumstances contributed to suicides among people with and without known MHP.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support people at risk, prevent reattempts, and help friends/family after a suicide occurs.

INTRODUCTION

BACKGROUND AND PURPOSE (255/250 words)

In 2016, nearly 45,000 suicides (15.6/100,000 [age-adjusted]) occurred in the United States (U.S.), among people ≥10 years old [1]. Between 1999 and 2016, suicide rates increased across sexes, racial/ethnic groups, and urbanization levels [2, 3]. Suicide is the 10th leading cause of death and is one of just three leading causes that are *increasing* [1, 4]. Additionally, rates of Emergency Department visits for nonfatal self-harm, a key risk factor for suicide, increased nearly 45% between 2001 and 2015 [1]. Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs [1].

The *National Strategy for Suicide Prevention(NSSP)* [5] calls for a public health approach to suicide prevention with efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal). Such an approach underscores that suicide is rarely caused by any single factor, but rather, is multi-determined. Despite the NSSP guidance, suicide prevention efforts largely focus on identifying and treating individuals with mental health problems (MHP) [6]. Other contributing circumstances include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, poor coping and problem-solving skills, and prior suicide attempts [5]. Expanded awareness of the additional circumstances that contribute to suicide risk apart from MHP, and action to address them, can help reach the nation's goal of

Comment [zaf9]: Need to edit this. Could be interpreted that contributing circumstances are increasing as well.

Comment [zaf9]: Is this still accurate?

reducing suicide rates 20% by 2025 [7]. To assist states in achieving this goal, this study analyzes state-specific trends in suicide rates, assesses the multiple contributing factors, and provides recommendations for multi-level comprehensive suicide prevention.

METHODS (256/250 words)

Suicide rates were analyzed for people aged ≥10 years only, as attributions of suicidal intent in younger children are variable [8]. Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases 10th Revision,* underlying-cause-of death codes X60-X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive three-year aggregate periods spanning 1999-2016. Rate estimates were age-adjusted to the U.S. year 2000 standard population and expressed per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same three-year data aggregates, employing weighted least squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes (AAPCs).

Characteristics (Table 2) and circumstances (Table 3) of suicide decedents ≥10 years, with and without known MHP, were compared in the 27 states with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines MHP as disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [9]. For this study, alcohol and other substance use disorders were not defined as MHP, and were examined in both groups. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. Decedents with and without known MHP were compared using Chi-square tests. Logistic regression analyses estimated adjusted odds ratios with 95% confidence intervals (CI), controlling for age group, sex, and race/ethnicity.

RESULTS (584/600 words)

The most recent overall suicide rates (representing 2014-2016) varied four-fold, from 6.9 (D.C.) to 29.2 (Montana) per 100,000 persons per year (Table 1). Across the study period, rates increased in all states, except Nevada (with the 9th highest current suicide rate), with absolute increases ranging from +0.8 (Delaware) to +8.1 (Wyoming) per 100,000. Percentage increases in rates ranged from +5.9% (Delaware) to +57.6% (North Dakota), with increases more than 30% observed in 25 states.

Modeled suicide rate trends indicated significant increases for 44 states, as well as for the U.S. overall (Table 1). By sex, modeled rate trends indicated significant increases in 34 states for males and in 43 states for females. Nationally, the model-estimated AAPC for the overall suicide rate was +1.5%. By sex, the national AAPC was +1.1% for males and +2.6% for females.

Suicide decedents without known MHP (N=11,039) were compared to those with MHP (N=9,407). While all decedents were predominately male (Table 2; 76.8%) and non-Hispanic white (83.6%), those without known MHP, relative to those with MHP, were more likely male (83.6% vs. 68.8%; adjusted odds ratio (aOR)=2.3, 95% CI = 2.2-2.5) and racial/ethnic minorities (odds ratio [OR] range: 1.2-2.1; 95% CI range [1.0-1.3] – [1.6-2.0]). Suicide decedents without known MHP also had significantly greater odds of perpetrating homicide-suicide (aOR = 2.9, 95% CI = 2.2-3.8), of firearm suicide (aOR = 1.6, 95% CI = 1.5-1.7), and of testing positive for alcohol (aOR = 1.2, 95% CI = 1.1-1.3). Among adult decedents, 20.1% and 15.3% of people without and with MHP, respectively, ever served, or were serving, in the U.S. military.

Comment [zaf9]: The comment made was that it wasn't clear how we defined MHP since substance use disorders are a diagnosis in DSM-V. Changed this to be more straightforward.

Comment [zaf9]: Correct definition for military services?

Although firearms were used most often, overall (48.5%), decedents with known MHP were more likely to die by suffocation (31.3 vs. 26.9%) and poisoning (19.8% vs. 10.4%) than those without known MHP .

All suicide decedents with known MHP (N=9,407) and approximately 85% without MHP (N=9,357) had available circumstances information (Table 3). People without known MHP were less likely to have any substance abuse problems (aOR=0.7, 95% CI=0.7-0.8). While two-thirds of those with known MHP had a history of mental health or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment.

Decedents without known MHP, versus those with known MHP had a significantly greater likelihood of any relationship problem/loss (45.1% vs. 39.6%), specifically intimate partner problems (30.2% vs. 24.1%), arguments/conflicts (17.5% vs. 13.6%), and recently perpetrating interpersonal violence (3.0% vs. 1.4%). They were also significantly more likely to have experienced other life stressors, such as criminal-legal problems (10.7% vs. 6.2%) or eviction/loss of home (4.3% vs. 3.4%), and they were more likely to have had a crisis within the preceding or upcoming two weeks (32.9% vs. 26.0%). Among both groups, the most common crises were intimate partner (36.2% vs. 34.9%) and physical health problems (13.8% vs. 12.9%), respectively.

Decedents without known MHP had significantly lower odds of recent release from any institution, but among those who were recently released (5.1%), those without a known MHP were significantly more likely to be released from a correctional facility (25.7% vs. 8.7%) or hospital (43.7% vs. 33.0%) than those with a known MHP. Among decedents with known MHP who were recently released from an institution (10.2%), 42.8% were released from psychiatric facilities.

Decedents without known MHP, compared to those with MHP, were less likely to have a history of suicidal ideation (aOR=0.4, 95% CI=0.4-0.5) and prior suicide attempt (aOR=0.3, 95% CI=0.3-0.3). Both groups disclosed suicide intent frequently, (22.4% vs. 24.5%), respectively.

Conclusions and Comments (680/700 words)

From 1999-2016, 44 states saw significant suicide rate increases. Half of the states experienced increases of 30% or more. Rates increased significantly in 34 states among males and 43 states among females. More research into the causes of these trends is necessary [10].

Researchers and practitioners regularly state that suicide is not caused by a single factor, however, the focus of suicide research and prevention practices, almost solely, focus on identify and treating MHP. The current study found that more than half of suicide decedents in NVDRS did *not* have a known MHP. This group suffered more relationship problems and life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises. This is particularly noteworthy in light of findings that suggest many suicides and attempts occur with minimal deliberation [12].

Among people with MHP, two-thirds had a history of mental health and/or substance abuse treatment and over half were in current treatment. This suggests that additional supports for this population are needed to keep them safe. This includes broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and cognitive-behavioral therapy. Additionally, greater access to behavioral health providers, especially in underserved areas is needed, as is expansion of healthcare systems needed that integrate physical and behavioral health and that better support suicide prevention and patient safety, especially through care transitions [11].

Study findings indicate that people with known MHP also experienced other life stressors such as job/financial, relationship, and/or physical health problems. These findings point to the need to both prevent the conditions

Comment [zaf9]: I kept this paragraph confined to percentages but did add some additional aOR's in other places.

Comment [zaf9]: We were asked to include disclosure of suicide intent.

Comment [zaf9]: Thinking to add something here like, This latter finding may indicate that the historical protective effect of being female may be changing.

Comment [zaf9]: May switch this out if we put in the above statement.

Comment [zaf9]: Replaced with prior version.

associated with mental health problems in the first place and the need to support people with known MHP to decrease their risk of poor social, health, and economic outcomes [13].

These results, together, underscore the importance of comprehensive statewide suicide prevention activities that address multiple factors associated with suicide. Prevention strategies may include: strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belongingness and access to informational, tangible, emotional, and social support, and identifying and better supporting people at risk. Other strategies include creating protective environments (e.g., reducing access to lethal means among people at risk, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for people with MHP and other life challenges), supporting family and friends after a suicide, and assuring safe reporting by the media in order to prevent suicide contagion [11]. Some states, such as Colorado, are planning and implementing such a comprehensive approach to suicide prevention [14].

These findings have at least three limitations. In the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent (i.e. decreasing suicide rates), or decreased percentages of such deaths over time (i.e. increasing suicide rates). Second, NVDRS is not yet nationally representative, the 27 states included in the current study represent 49.6% of the U.S. population. Third, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can impact data completeness and accuracy. Studies including in-depth interviews with next-of-kin often see greater attributions to MHP and substance abuse disorders, however many methodological variations across studies exist [15]. It is likely that some people without known MHP in the current study were experiencing mental health challenges that were unknown, and hence unreported by key informants. However, any lack of awareness of decedent MHP suggests, even further, the importance of addressing the range of contributing circumstances.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices* [11] to better understand their suicide problem and prioritize evidence-based comprehensive suicide prevention.

Acknowledgments
The authors acknowledge Robert Anderson, Holly Hedegaard, and Margaret Warner from the Division of Vital Statistics, National Center for Health Statistics, CDC, for their statistical consultation.

Conflict of Interest No conflicts of interest were reported.

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References:

Comment [zaf9]: Is this confirmed, Tom?

Comment [tgs9]: This is from the 2015 NVDRS SS

Comment [zaf9]: Need to consider this part further.

Comment [zaf9]: Is this still ok?

Comment [zaf9]: Cory had a great idea here so took out, M ental illness is an important risk factor for suicide, and is one of many requiring preventive action. She said the media would probably just take away Mental illness is an important risk factor, period.

Comment [zaf9]: Was Sally at the meeting where we discussed Scott's table? I don't believe so but wanted to double check and didn't want to forget her if she was there.

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Tables and Figures (attachments)

Table 1 and Figure 1.doc

Tables 2 and 3.pdf

Word Count: 1775/1800

DRAFT

Rev 3.19.18 v3

Short title: Vital Signs: Increasing Trends in State Suicide Rates and Contributing Circumstances

Deborah M. Stone, ScD;[1] Thomas R. Simon PhD;[1] Katherine A. Fowler, PhD;[1] Scott R. Kegler, PhD;[2] Keming Yuan, MS;[1] Kristin M. Holland, PhD;[1] Asha Z. Ivey-Stephenson, PhD;[1] Alex E. Crosby, MD[1]

Structured abstract (256252/250 words—this word count is not included in the 1800 max for the remainder)

Background: Overall sSuicide rates have been rising in the United States since 1999. Examining state-level trends in suicide and its multiple contributing circumstances, can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates, by state and sex, among people aged ≥10 years, were assessed using data from the National Vital Statistics System. Changes in rates were examined across six consecutive three-year periods from 1999-2016. TheCDC's National Violent Death Reporting System (2015), covering 27 states, was used to examine the precipitating circumstances among suicide decedents with and without known mental health problems (MHP).

Results: Forty-four states saw statistically significant sSuicide rates increases increased significantly from 1999-2016 in 44 states. In 25 states, rates increased by 30% or more. Male suicide rates increased significantly in 34 states. while fFemale rates increased significantly in 43 states. People with (46%) and without (54%) known MHP had both differing and similar circumstances precipitating suicide. Several circumstance, such as any relationship problems/loss (39.6 and 45.1%, $p \leq .01$), any life stressors/loss (49.7 and 54.2%, $p \leq .01$), and recent crises (26.0 and 32.9%, $p \leq .01$), respectively, were more likely among those without known MHP, but were common across groups.

Conclusions: Suicide rates rose significantly across most states from 1999-2016. Varied circumstances beyond MHP alone contributed to suicides among people with and without known MHP.

Implications for Public Health Practice: States can use a comprehensive public health approach based on the best available evidence to prevent suicide risks before they occur, identify and support people already at risk, prevent reattempts, and help friends/family after a suicide occurs.

INTRODUCTION

BACKGROUND AND PURPOSE (255/260 words)

In 2016, nearly 45,000 suicides (15.6/100,000) occurred in the United States (U.S.), among people ≥10 years old [1]. Between 1999 and 2016, suicide rates increased across sexes, racial/ethnic groups, and urbanization levels [2, 3]. Suicide is the 10th leading cause of death and is among the only leading causes to be *increasing* [1, 4]. Additionally, rates of Emergency Department visits for nonfatal self-harm injury, a key risk factor for suicide, increased more than 40% between 2001 and 2015 [1]. Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs [1].

The *National Strategy for Suicide Prevention(NSSP)* [5] calls for a public health approach to suicide with prevention with efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal), of the social ecology. Such an approach underscores that suicide is rarely caused by any single factor alone, but rather, is multi-determined. Despite the NSSP guidance, suicide prevention efforts largely focus on identifying and treating individuals with mental health problems (MHP) [6]. Other associated contributing risk factors include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, poor coping and problem-solving skills, and prior suicide attempts, among others [5]. Expanded

Comment [BE(]: Sometimes it is referred to as a 'contributing circumstance' and sometimes its referred to as a 'contributing factor'. I wonder if its

Comment [FC(]: Can a couple of words be added here to reflect a date since rates have been rising. I see word count is an issue and I think a couple of words can

Comment [FC(]: Style consideration. Since focus on suicide and states is clear, may not these words twice in sentence which would reduce word count. A few

Comment [FC(]: The transition from reading NVDRS covers 27 states to methods to the first line in the results referring to 44 states made me pause and

Comment [FC(]: Unclear if this was supposed to be a reference or can come out.

Comment [JRV8]: Just a suggestion and may not be feasible, but would suggest not using MHP through the document. Mental health problems doesn't seem

Comment [BE(]: I think this is a Significant finding should we say more about it the fact that it is increasing more in women?

Comment [FC(]: I think edits are needed here for a few reasons. I am finding the statements that there are differences and similarities vague and hard to follow

Comment [FC(]: Please double check. I am getting 15.9 from WISQARS

Comment [BE(]: Can we be more specific – is it the only or is it one of only X leading causes increasing – 'among the only' is vague?

Comment [FC(]: Please double check. Wonder if this might have been calculated for all ages and not limited to ≥10 years.

Comment [JRV8]: Suggest identifying this as a US Surgeon General report.

Comment [BE(]: Is it better to say social ecology (which I think many think of social, environmental and economic) versus I think what is used most often the

awareness of the additional circumstances that contribute to suicide risk apart from MHP, can help reach the nation's goal of reducing suicide rates 20% by 2025 [7]. To assist states in achieving this goal, this study analyzes state-specific trends in suicide rates, assesses the multiple contributing factors ~~associated with suicide~~, and provides recommendations for multi-level comprehensive suicide prevention.

METHODS (257/260 words)

Suicide rates were analyzed for those aged 10 years and older (because of variability in attributions of suicidal intent, younger children are excluded) [8]. Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases 10th Revision* [ICD-10] underlying-cause-of death codes X60-X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive three-year aggregate periods from 1999-2016. Rate estimates were age-adjusted to the U.S. year 2000 standard population and expressed per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same three-year data aggregates, employing weighted least squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes (AAPCs).

Data from 2015 from the 27 states with complete data participating in ~~the~~CDC's National Violent Death Reporting System (NVDRS), ages 10 and older, were used to compare the characteristics among suicide decedents with and without known current ~~mental health problems~~ (MHP). MHP are defined in NVDRS as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [9], except alcohol and other substance use disorders (captured separately). NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. Decedents with and without known MHP were compared using Chi-square tests; logistic regression was used to estimate adjusted odds ratios with 95% confidence intervals (CI), controlling for age group, sex, and race/ethnicity.

RESULTS (612/591 words)

The most recent overall suicide rates (representing 2014-2016) ranged from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year, a four-fold difference (Table 1). Across the entire study period, rates increased in all but one state (Nevada), with absolute increases ranging from +0.2 (Delaware) to +8.1 (Wyoming) per 100,000. Percentage increases in rates ranged from +5.9% (Delaware) to +57.6% (North Dakota), with percentage increases of at least 30% observed in 25 states.

Modeled suicide rate trends indicated significant increases for 44 states, as well as for the U.S. overall (Table 1). By sex, modeled rate trends indicated significant increases in 34 states for males and in 43 states for females. Nationally, the model-estimated AAPC for the overall suicide rate was +1.5%. By sex, the national AAPC was +1.1% for males and +2.6% for females.

Suicide decedents with (N=9,407) and without (N=11,039) known MHP were compared. ~~While b~~Both groups were predominately male and non-Hispanic white. ~~, s~~Suicide decedents without known MHP relative to those with known MHP were more likely to be male (83.6% vs. 68.8%; p≤.01), and racial/ethnic minorities (odds ratio [OR] range: 1.2-2.1; 95% CI range [1.0-1.3] – [1.6-2.0]). ~~They~~Suicide decedents without known MHP also had significantly greater odds of perpetrating homicide-suicide (adjusted odds ratio [aOR] = 2.9, 95% CI = 2.2-3.8), of firearm suicide (aOR = 1.6, 95% CI = 1.5-1.7), and of positive toxicology results for alcohol (aOR = 1.2, 95% CI = 1.1-1.3). Fifteen percent of ~~those~~adult decedents with known MHP, and 20% without, ~~ever~~ had served or were serving ~~served~~ in the U.S. military.

Comment [BE(]: Is it really the 'nation's goal' – versus the goal set by the American Foundation for Suicide Prevention.

Comment [JRV8]: Sentence has a lot of different points. It may be easier to read if it were two sentences. Suggestion:

Data from the National Violent Death Reporting System (NVDRS) were used to compare characteristics among suicide decedents with and without known current mental health programs. Complete data from 27 states participating in NVDRS in 2015 were used for this analyses.

Comment [FC(]: I am confused by how the alcohol and substance use disorder exception is described. DSM-5 does have an alcohol use disorder diagnosis and a substance use disorder dx.

Comment [FC(]: Some labeling of the tables and how reflected in the text need some modification. There are current two "Table 1" in attachments (i.e., state trends; select demographics). The two NVDRS tables and figure 1 don't appear to

Comment [BE(]: Per our discussion in our last VS group meeting, should we add a note that despite NV not increases, they still have a significantly high rate of suicide?

Comment [FC(]: Please double check. Table reflects +0.8

Comment [FC(]: Suggest revising in order to allow in the next sentence the comparison group to be clear and the order the %'s should be considered clearer. Tracked is an idea.

Comment [FC(]: Wonder if need to be clear here this is limited to 18+. Tracked might be a simple approach to consider.

I have seen MMWR want to present %'s to first decimal place consistently. Here is

Comment [JRV8]: I realize this adds words so you may not be able to do this but the "ever" in the original sentence was confusing/stumbling block to me as a I read. Not sure if the additional language is correct – vets and active duty or just

Although firearms were used most often in both groups, decedents with known MHP died by poisoning more than those without known MHP (19.8% vs. 10.4%; $p \leq .01$), most frequently by over-the-counter/otherwise unclassified drugs (35.8%), opioids (32.7%), antidepressants (34.6%) or benzodiazepines (25.1%).

All suicide decedents with known MHP (N=9,407) and approximately 85% without (N=9,357) had precipitating circumstances ~~information~~ (Table 2 or 3??). People with known MHP were more likely to have any substance abuse problems (31.6% vs. 25%, $p \leq .01$). While two-thirds of those with known MHP had a history of MH or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment at the time of their deaths.

Decedents without known MHP, versus those with known MHP had a greater likelihood of any relationship problem/loss (45.1% ~~and~~vs. 39.6%, $p \leq .01$), specifically intimate partner problems (30.2% ~~and~~vs. 24.1%, $p \leq .01$), arguments/conflicts (17.5% ~~and~~vs. 13.6%, $p \leq .01$), and recently perpetrating interpersonal violence (3.0% ~~and~~vs. 1.4%, $p \leq .01$). They were also more likely to have experienced other life stressors, such as criminal-legal problems (10.7% ~~and~~vs. 6.2%, $p \leq .01$) or eviction/loss of home (4.3% ~~and~~vs. 3.4%, $p \leq .01$), and they were more likely to have had a crisis within the preceding or upcoming two weeks (32.9% ~~and~~vs. 26.0%, $p<.01$). Among both groups, the most common crises were intimate partner (35.6%) and physical health (13.4%) problems.

Decedents without known MHP had significantly lower odds of recent release from any institution, but among those who were recently released, those without a known MHP were more likely to be released from a correctional facility (25.7% vs. 8.7%, $p \leq .01$) or hospital (43.7% vs. 33.0%, $p \leq .01$) than those with a known MHP. Among decedents with known MHP recently released from an institution (10.2%), 42.8% were released from psychiatric facilities.

Suicide decedents without known MHP were more likely than those without known MHP to leave a suicide note (35.1% ~~and~~vs. 31.8%, $p \leq .01$). ~~while d~~Decedents with known MHP, compared to those without known MHP, were more likely to have a history of suicidal ideation (40.8% vs. 23.0%, $p \leq .01$) and attempts (29.4% vs. 10.3%, $p \leq .01$).

Conclusions and Comments (655/715 words)

From 1999-2016, 44 states saw significant suicide rate increases. Half of the states experienced increases of 30% or more. Rates increased significantly in 34 states among males and 43 states among females. More research into the causes of these trends is necessary [10].

One important factor associated with suicide is MHP. Nearly half of suicide decedents in NVDRS had a known MHP. This group was challenged by comorbid substance abuse problems (31.6%) and histories of suicidal ideation (40.8%) and attempts (29.4%). While two-thirds of people with known MHP had a history of MH and/or substance abuse treatment and over half were in treatment at the time of their deaths, additional support ~~could~~ may help address the needs of this vulnerable population. This includes broader implementation of affordable and evidence-based treatments, such as doctor-patient collaborative care models and cognitive-behavioral therapy. Additionally, greater access to behavioral health providers, especially in underserved areas is important, as is healthcare systems ~~change~~ that supports suicide prevention and patient safety through care transitions [11].

While mental health problems are a significant contributor to suicide, 54% of suicide decedents in this study did *not* have a known MHP. This group suffered more relationship problems and life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises. This is noteworthy in light of findings that suggest many suicides and attempts occur with minimal deliberation time, particularly among people without mental health disorders and who faced impending life crises [12].

Comment [FC(]: I think the comparison group %'s are needed. For instance, drugs (35.8% vs. 35.8%).

I think the presentation of the %'s would be easier here and later on in the results if the p's came out and the text could simply reflect "significant differences" or some variation of indicating in the groups were different.

Comment [BE(]: Sometimes criminal-legal is hyphenated and sometimes it's not.

Comment [FC(]: The % reported in this sentence appear to be only for the group with MHPs. Based on the sentence wording, the % for both groups need to be reported.

Comment [FC(]: Please double check number. Table reflects 33.8%

Comment [FC(]: My two cents: I think we should do more to raise attention to the fact that almost a quarter of both groups disclosed suicide intent. This is a true prevention opportunity so I think this is a common risk to highlight. Knowing space constraints, I think this is more important to highlight than the presence of a suicide note which often doesn't inform prevention. I suggest adding into results and into discussion.

Comment [FC(]: I feel that MMWRs typically don't do a lot of repeat of the specific data findings in the discussion. I think the numbers could come out here. I think it would be helpful to put this into a larger context, indicating whether this is consistent with other research. I also

Comment [BE(]: I would add the percentage in parenthesis (X%).

People with known MHP also experienced other life stressors such as job and/or financial~~, problems,~~ relationship ~~problems~~, and/or physical health problems. These findings point to the need to both prevent the conditions associated with mental health problems in the first place and the need to support people with known MHP to decrease their vulnerability to poor social, health, and economic outcomes [13].

These results underscore the importance of comprehensive statewide suicide prevention activities that go beyond a focus on ~~MH~~mental health treatment alone. Prevention strategies may include: strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills, especially early in life to manage everyday stressors and prevent future relationship problems; and promoting social connectedness to increase a sense of belongingness and access to informational, tangible, emotional, and social support~~, as needed~~. Other strategies ~~indicated by these results~~ include creating protective environments (e.g., reducing access to lethal means among people at risk, creating organizational and workplace policies to promote help-seeking and positive social norms), supporting family and friends after a suicide ~~has taken place~~, and assuring safe reporting by the media in order to prevent suicide contagion [11]. Some states, such as Colorado, are planning and implementing a comprehensive statewide approach to suicide prevention [14].

The ~~study~~ findings have at least three limitations. In the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent, or by decreased percentages of such deaths over time, which likely include some unrecognized suicides. Second, NVDRS is not yet nationally representative, and this study's ~~. This study used the most current data available which~~ data include~~des~~ 27 states that represent ~~half (~~49.6%~~)~~ of the U.S. population. Third, abstractors of NVDRS data are limited to data included in investigative reports. ~~For example, m~~Medical and ~~MH~~mental health information ~~are not captured directly from medical records but~~ come from key informants (e.g., family, friends) via coroner/medical examiner reports and can ~~. Therefore, informant knowledge~~ impact~~s~~ the data completeness and accuracy~~, of the information reported, and~~ Some studies including in-depth interviews with family members show ~~often see~~ greater attributions to ~~MH~~mental health and substance abuse disorders than medical records~~, however methodological variation across studies exists~~ [15]. It is likely that some people without known MHP in the current study were experiencing mental health challenges at the time of death that were either not known or reported by informants~~, or were not captured in NVDRS's primary data sources. The lack of awareness of a mental health problem suggests the importance of addressing the range of contributing circumstances~~.

Suicide is a growing public health problem. Mental illness is an important risk factor for suicide, and is one of many requiring preventive action. Data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices* [11] can help states and communities better understand their suicide problem and prioritize comprehensive suicide prevention.

Acknowledgments
The authors acknowledge Robert Anderson, Holly Hedegaard, and Margaret Warner from the Division of Vital Statistics, National Center for Health Statistics, CDC, for their statistical consultation.

Conflict of Interest No conflicts of interest were reported.

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Author Affiliations:

Comment [FC(]: I suggest pulling this out into a separate paragraph. If contained in the above, it seems to undercut the main point that many suicides don't have MPH. A new paragraph might need a lead-in sentence or maybe start with the current last sentence to frame points about common risks.

Comment [BE(]: Should this be 'and', 'or' or 'and/or'?

Comment [JRV8]: Suggest using "risk of" rather than "vulnerability to", as vulnerability sometimes can have negative connotations aligned with weakness.

Comment [FC(]: I think it is fine that the TP strategies are presented in different areas of the discussion. I don't easily see "identify and support people at-risk". I think that can go in the proposed paragraph immediately above when talking about common risk factors. In adding that, suggest adding some examples of approaches (e.g., crisis intervention, gatekeeper training).

Comment [FC(]: I am not easily following this point. Can this be stated more simply such as "…impacted by variations of undetermined injury deaths, which likely….

To help w/word count, offer a couple of suggestions in next few sentences to streamline. Certainly take/leave what you like and check for accuracy.

Comment [BE(]: Do you mean 'NOT' reported by informants?

Comment [FC(]: To me, this sentence puts the spotlight back on mental illness and makes it likely it will be the take home message of media reporting. If that isn't the goal of this VS, suggest framing broadly. Ideas: *Effective approaches are available to prevent or ameliorate many*

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Tables and Figures (attachments)

Table 1 and Figure 1.doc

Tables 2 and 3.pdf

Word Count: 1826/1800

DRAFT

From: Media@cdc.gov (CDC)
Sent: 7 Jun 2018 09:01:36 -0400
To: Media@cdc.gov (CDC)
Subject: CDC Press Release: Suicide rates rising across the U.S. *Embargoed Until 1 P.M. EDT, Thursday, June 7, 2018*
Attachments: PressMaterials_VitalSigns_Suicide_060718.zip
Importance: High

Press Release

Embargoed until 1:00 pm ET
Thursday, June 7, 2018
Contact: CDC Media Relations
404-639-3286

Suicide rates rising across the U.S.

Comprehensive prevention goes beyond a focus on mental health concerns

Suicide rates have been rising in nearly every state, according to the latest *Vital Signs* report by the Centers for Disease Control and Prevention (CDC). In 2016, nearly 45,000 Americans age 10 or older died by suicide. Suicide is the 10th leading cause of death and is one of just three leading causes that are on the rise.

Suicide is rarely caused by a single factor. Although suicide prevention efforts largely focus on identifying and providing treatment for people with mental health conditions, there are many additional opportunities for prevention.

"Suicide is a leading cause of death for Americans – and it's a tragedy for families and communities across the country," said CDC Principal Deputy Director Anne Schuchat, M.D. "From individuals and communities to employers and healthcare professionals, everyone can play a role in efforts to help save lives and reverse this troubling rise in suicide."

Many factors contribute to suicide

For this *Vital Signs* report, CDC researchers examined state-level trends in suicide rates from 1999-2016. In addition, they used 2015 data from CDC's National Violent Death Reporting System, which covered 27 states, to look at the circumstances of suicide among people with and without known mental health conditions.

Researchers found that more than half of people who died by suicide did *not* have a known diagnosed mental health condition at the time of death. Relationship problems or loss, substance misuse; physical health problems; and job, money, legal or housing stress often contributed to risk for suicide. Firearms were the most common method of suicide used by those with and without a known diagnosed mental health condition.

State suicide rates vary widely

The most recent overall suicide rates (2014-2016) varied four-fold; from 6.9 per 100,000 residents per year in Washington, D.C. to 29.2 per 100,000 residents in Montana.

Across the study period, rates increased in nearly all states. Percentage increases in suicide rates ranged from just under 6 percent in Delaware to over 57 percent in North Dakota. Twenty-five states had suicide rate increases of more than 30 percent.

Wide range of prevention activities needed

The report recommends that states take a comprehensive public health approach to suicide prevention and address the range of factors contributing to suicide. This requires coordination and cooperation from every sector of society: government, public health, healthcare, employers, education, media and community organizations.

To help states with this important work, in 2017 CDC released a technical package on suicide prevention that describes strategies and approaches based on the best available evidence. This can help inform states and communities as they make decisions about prevention activities and priorities.

Everyone can help prevent suicide:

- Learn the warning signs of suicide to identify and appropriately respond to people at risk. Find out how this can save a life by visiting: www.BeThe1to.com
- Reduce access to lethal means – such as medications and firearms – among people at risk of suicide.
- Contact the National Suicide Prevention Lifeline for help: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org

The media can avoid increasing risk when reporting on suicide by:

- Following and sharing recommendations available at www.reportingonsuicide.org (for example, avoiding dramatic headlines or explicit details on suicide methods);
- Providing information on suicide warning signs and suicide prevention resources; and
- Sharing stories of hope and healing.

Vital Signs is a CDC report that typically appears on the first Tuesday of the month as part of the CDC journal *Morbidity and Mortality Weekly Report*. The report provides the latest data and information on key health indicators, and what can be done to drive down these health threats.

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U.S. Department of Health and Human Services

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Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
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June 8, 2018

Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

Deborah M. Stone, ScD[1]; Thomas R. Simon PhD[1]; Katherine A. Fowler, PhD[1]; Scott R. Kegler, PhD[2]; Keming Yuan, MS[1]; Kristin M. Holland, PhD[1]; Asha Z. Ivey-Stephenson, PhD[1]; Alex E. Crosby, MD[1]

Abstract

Introduction: Suicide rates in the United States have risen nearly 30% since 1999, and mental health conditions are one of several factors contributing to suicide. Examining state-level trends in suicide and the multiple circumstances contributing to it can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among persons aged ≥10 years, by state and sex, across six consecutive 3-year periods (1999–2016), were assessed using data from the National Vital Statistics System for 50 states and the District of Columbia. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health conditions.

Results: During 1999–2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases >30%. Rates increased significantly among males and females in 34 and 43 states, respectively. Fifty-four percent of decedents in 27 states in 2015 did not have a known mental health condition. Among decedents with available information, several circumstances were significantly more likely among those without known mental health conditions than among those with mental health conditions, including relationship problems/loss (45.1% versus 39.6%), life stressors (50.5% versus 47.2%), and recent/impending crises (32.9% versus 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states during 1999–2016. Various circumstances contributed to suicides among persons with and without known mental health conditions.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends and family members in the aftermath of a suicide.

INSIDE

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Continuing Education examination available at https://www.cdc.gov/mmwr/cme/conted_info.html#weekly.

U.S. Department of Health and Human Services
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Introduction

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (*1*). From 1999 to 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (*2,3*). Suicide rates have also increased among persons in all age groups <75 years, with adults aged 45–64 having the largest absolute rate increase (from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (232,108) during the same period (*1,3*). Suicide is the tenth leading cause of death and is one of just three leading causes that are increasing (*1,4*). In addition, rates of emergency department visits for nonfatal self-harm, a main risk factor for suicide, increased 42% from 2001 to 2016 (*1*). Together, suicides and self-harm injuries cost the nation approximately $70 billion per year in direct medical and work loss costs (*1*).

The National Strategy for Suicide Prevention (*5*) calls for a public health approach to suicide prevention with efforts spanning multiple levels (individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is determined by multiple factors. Despite this call to action, suicide prevention largely focuses on identifying and referring suicidal persons to mental health treatment and preventing reattempts (*6*). In addition to mental health conditions and prior suicide attempts, other contributing circumstances include social and economic problems, access to lethal means (e.g., substances, firearms) among persons at risk, and poor coping and problem-solving skills (*5*). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them can help reach the national goal, established by the National Action Alliance of Suicide Prevention and the American Foundation for Suicide Prevention, of reducing the annual suicide rate 20% by 2025 (*7*). To assist states in achieving this goal, CDC analyzed state-specific trends in suicide rates and assessed the multiple contributing factors to suicide; this report presents options for strategies to include in comprehensive suicide prevention efforts that are based on the best available evidence.

Methods

Suicide rates were analyzed for persons aged ≥10 years because determining suicidal intent in younger children can be difficult (*8*). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases, Tenth Revision,* underlying-cause-of death codes X60–X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive 3-year aggregate periods spanning 1999–2016 (1999–2001; 2002–2004; 2005–2007; 2008–2010; 2011–2013; and 2014–2016). Rate estimates were age-adjusted to the U.S. 2000 standard population and expressed

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per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same 3-year data aggregates, employing weighted least-squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes.

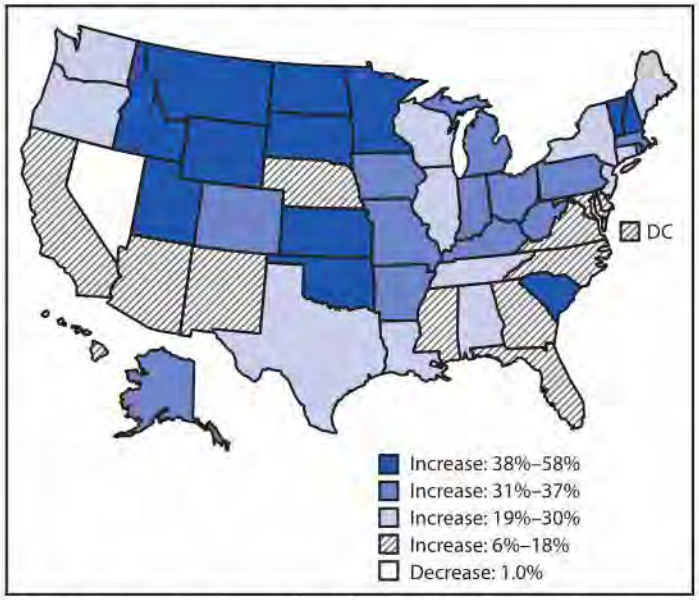
Characteristics of persons aged ≥10 years who died by suicide, with and without known mental health conditions, and the circumstances surrounding the suicides were compared in the 27 states* with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines mental health conditions as disorders and syndromes listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*9*), with the exception of problematic alcohol use and other substance use that are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. A range of circumstances (relationship problems, life stressors, and recent or impending crises) have been identified as potential risk factors for suicide in NVDRS. Circumstances captured are those identified as contributing to suicide in coroner/medical examiner or law enforcement reports, which reflect information provided by family and friends at the time of death. Decedents could have experienced multiple circumstances. Decedents with and without known mental health conditions were compared using chi-square tests. Logistic regression analyses were used to estimate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), controlling for sex, age group, and race/ethnicity.

Results

The most recent overall suicide rates (representing 2014–2016) varied fourfold, from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Across the study period, rates increased in all states except Nevada (where the rate was consistently high throughout the study period), with absolute increases ranging from 0.8 per 100,000 (Delaware) to 8.1 (Wyoming). Percentage increases in rates ranged from 5.9% (Delaware) to 57.6% (North Dakota), with increases >30% observed in 25 states (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785) (Figure).

Modeled suicide rate trends indicated significant increases in 44 states, among males (34 states) and females (43 states), as well as for the United States overall (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Nationally, the model-estimated average annual percentage change for the overall suicide rate was an increase of 1.5%. By sex, estimated national rate trends further indicated significant average annual percentage change increases for males (1.1%) and females (2.6%) (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785).

FIGURE. Percent change in annual suicide rate,* by state — United States, from 1999–2001 to 2014–2016



* Per 100,000 population, age-adjusted to the 2000 U.S. standard population.

Suicide decedents without known mental health conditions (11,039; 54.0%) were compared with those with known mental health conditions (9,407; 46.0%) for 27 states. Whereas decedents were predominantly male (76.8%) (Table 1) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely to be male (83.6% versus 68.8%; odds ratio [OR] = 2.3, 95% CI = 2.2–2.5) and belong to a racial/ethnic minority (OR range = 1.2–2.0). Suicide decedents without known mental health conditions also had significantly higher odds of perpetrating homicide followed by suicide (aOR = 2.9, 95% CI = 2.2–3.8). Among decedents aged ≥18 years, 20.1% of those without known mental health conditions and 15.3% of those with mental health conditions had previously served in the U.S. military or were serving at the time of death.

Whereas firearms were the most common method of suicide overall (48.5%), decedents without known mental health conditions were more likely to die by firearm (55.3%) and less likely to die by hanging/strangulation/suffocation (26.9%) or poisoning (10.4%) than were those with known mental health conditions (40.6%, 31.3%, and 19.8%, respectively). These differences remained significant in the adjusted models.

Toxicology testing was less likely to be performed for decedents without known mental health conditions. Among those with toxicology results, decedents without known mental health

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

TABLE 1. Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	**15,702 (76.8)**	6,469 (68.8)	9,233 (83.6)	<0.01	2.3 (2.2–2.5)	NA
Female	**4,744 (23.2)**	2,938 (31.2)	1,806 (16.4)	<0.01	0.4 (0.4–0.5)	NA
Age group (yrs)**						
10–24	**2,804 (13.7)**	1,211 (12.9)	1,593 (14.4)	<0.01	1.1 (1.1–1.2)	NA
25–44	**6,456 (31.6)**	3,036 (32.3)	3,420 (31.0)	<0.05	0.9 (0.9–1.0)	NA
45–64	**7,718 (37.7)**	3,820 (40.6)	3,898 (35.3)	<0.01	0.8 (0.8–0.8)	NA
≥65	**3,468 (17.0)**	1,340 (14.2)	2,128 (19.3)	<0.01	1.4 (1.3–1.5)	NA
Race/Ethnicity						
White, non-Hispanic	**17,102 (83.6)**	8,165 (86.8)	8,937 (81.0)	<0.01	0.6 (0.6–0.7)	NA
Black, non-Hispanic	**1,228 (6.0)**	411 (4.4)	817 (7.4)	<0.01	1.7 (1.5–2.0)	NA
American Indian/Alaska Native, non-Hispanic	**378 (1.8)**	112 (1.2)	266 (2.4)	<0.01	2.0 (1.6–2.6)	NA
Asian, non-Hispanic	**576 (2.8)**	235 (2.5)	341 (3.1)	<0.05	1.2 (1.1–1.5)	NA
Hispanic	**1,096 (5.4)**	463 (4.9)	633 (5.7)	<0.05	1.2 (1.0–1.3)	NA
Other	**66 (0.3)**	21 (0.2)	45 (0.4)	<0.05	1.8 (1.1–3.1)	NA
Extended demographics						
Ever served in military††	**3,429 (17.8)**	1,354 (15.3)	2,075 (20.1)	<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	**240 (1.2)**	104 (1.1)	136 (1.3)	NS	1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident type						
Single suicide	**20,063 (98.2)**	9,318 (99.1)	10,745 (97.4)	<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	**319 (1.6)**	64 (0.7)	255 (2.3)	<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	**64 (0.3)**	25 (0.3)	39 (0.4)	NS	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	**9,909 (48.5)**	3,821 (40.6)	6,088 (55.3)	<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	**5,907 (28.9)**	2,940 (31.3)	2,967 (26.9)	<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	**3,003 (14.7)**	1,861 (19.8)	1,142 (10.4)	<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	**1,021 (34.0)**	666 (35.8)	355 (31.1)	<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	**944 (31.4)**	608 (32.7)	336 (29.4)	NS	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	**800 (26.6)**	644 (34.6)	156 (13.7)	<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	**624 (20.8)**	468 (25.1)	156 (13.7)	<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	**219 (7.3)**	195 (10.5)	24 (2.1)	<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	**1,595 (7.8)**	780 (8.3)	815 (7.4)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)

See table footnotes on next page.

conditions were less likely to test positive for any substance overall (aOR = 0.8, 95% CI = 0.7–0.8), including opioids (aOR = 0.90, 95% CI = 0.81–0.99), but were more likely to test positive for alcohol (aOR = 1.2, 95%, CI = 1.1–1.3).

Information on circumstances surrounding suicide were available for all decedents with mental health conditions (9,407) and approximately 85% of those without known mental health conditions (9,357) in 27 states (Table 2). Persons without known mental health conditions were less likely to have any problematic substance use (aOR = 0.7, 95% CI = 0.7–0.8) than were persons with known mental health conditions. Whereas two thirds of decedents with known mental health conditions had a history of mental health or substance use treatment (67.2%), just over half (54.0%) were in treatment at the time of death.

Decedents without known mental health conditions had a significantly higher likelihood of any relationship problem/loss (45.1%) than did those with known mental health conditions (39.6%), specifically intimate partner problems (30.2% versus 24.1%), arguments/conflicts (17.5% versus 13.6%), and perpetrating interpersonal violence in the past month (3.0% versus 1.4%). Decedents without known mental health conditions were also more likely than were those with known mental health conditions to have experienced any life stressors (50.5% versus 47.2%) such as recent criminal legal problems (10.7% versus 6.2%) or eviction/loss of home (4.3% versus 3.4%) and were more likely to have had a recent or impending (within the preceding or upcoming 2 weeks, respectively) crisis (a current or acute event thought to contribute to the suicide) (32.9% versus 26.0%). All of these differences remained significant in the adjusted models. Physical health problems and job/financial problems were commonly contributing stressors among both persons without mental health conditions (23.2% and 15.6%, respectively) and those with mental health conditions (21.4%

TABLE 1. (*Continued*) Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Toxicology results						
Any toxicology testing	**13,317 (65.1)**	6,658 (70.8)	6,659 (60.3)	<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	**9,913 (74.4)**	5,192 (78.0)	4,721 (70.9)	<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected* **						
Alcohol						
Tested	**10,950 (53.6)**	5,409 (57.5)	5,541 (50.2)	<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	**4,442 (40.6)**	2,115 (39.1)	2,327 (42.0)	<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	**8,554 (41.8)**	4,258 (45.3)	4,296 (38.9)	<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	**2,279 (26.6)**	1,238 (29.1)	1,041 (24.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	**8,124 (39.7)**	4,226 (44.9)	3,898 (35.3)	<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	**2,464 (30.3)**	1,639 (38.8)	825 (21.2)	<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	**7,978 (39.0)**	3,866 (41.1)	4,112 (37.2)	<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	**499 (6.3)**	216 (5.6)	283 (6.9)	<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	**7,615 (37.2)**	3,696 (39.3)	3,919 (35.5)	<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	**736 (9.7)**	376 (10.2)	360 (9.2)	NS	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	**6,569 (32.1)**	3,127 (33.2)	3,442 (31.2)	<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	**1,471 (22.4)**	710 (22.7)	761 (22.1)	NS	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	**5,425 (26.5)**	3,103 (33.0)	2,322 (21.0)	<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	**2,214 (40.8)**	1,735 (55.9)	479 (20.6)	<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviations: CI = confidence interval; NA = not adjusted; NS = not significant; OR = odds ratio.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology testing.

*** Denominator for each positive group is the number tested for the substance in that group.

and 16.8%, respectively). Similarly, among all persons with recent crises, intimate partner problems were the most common types and did not differ by group.

Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR = 0.5, 95% CI = 0.4–0.5). Among those recently released, decedents without known mental health conditions were significantly more likely than decedents with mental health conditions to have been released from a correctional facility (25.7% versus 8.7%), hospital (43.7% versus 33.0%), or other facility, such as an alcohol/substance use treatment facility (24.2% versus 11.6%). Among decedents with known mental health conditions who were recently released from an institution, 46.7% were released from psychiatric facilities.

Decedents without known mental health conditions were significantly less likely to have a history of suicidal ideation (23.0%) or prior suicide attempts (10.3%) compared with those with known mental health conditions (40.8% and 29.4%, respectively). Suicide intent was disclosed by 22.4% and 24.5% of persons without and with known mental health conditions, respectively.

Conclusions and Comments

During 1999–2016, suicide rates increased significantly in 44 states, and 25 states experienced increases >30%. Rates increased significantly among males in 34 states, and females in 43 states. Additional research into the specific causes of these trends is needed. Data from the 27 states participating in NVDRS provide important insight into circumstances surrounding suicide and can help states identify prevention priorities.

TABLE 2. Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	**18,764 (91.8)**	9,407 (100)	9,357 (84.8)	<0.01	N/A	N/A
Mental health						
Any current diagnosed mental health condition**						
Depression/Dysthymia	—††	7,076 (75.2)	N/A	N/A	N/A	N/A
Anxiety disorder	—††	1,579 (16.8)	N/A	N/A	N/A	N/A
Bipolar disorder	—††	1,431 (15.2)	N/A	N/A	N/A	N/A
Schizophrenia	—††	509 (5.4)	N/A	N/A	N/A	N/A
PTSD	—††	424 (4.5)	N/A	N/A	N/A	N/A
ADD/ADHD	—††	226 (2.4)	N/A	N/A	N/A	N/A
Not specified	—††	760 (8.1)	N/A	N/A	N/A	N/A
Current depressed mood§§	**7,038 (37.5)**	3,962 (42.1)	3,076 (32.9)	<0.01	0.7 (0.6–0.7)	0.7 (0.6–0.7)
Problematic substance use						
Any	**5,319 (28.3)**	2,976 (31.6)	2,343 (25.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Alcohol	**3,268 (17.4)**	1,862 (19.8)	1,406 (15.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Other	**3,084 (16.4)**	1,768 (18.8)	1,316 (14.1)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Treatment						
Current mental health/substance use treatment	**5,141 (27.4)**	5,077 (54.0)	64 (0.7)	<0.01	0.01 (0.01–0.01)	0.01 (0.01–0.01)
Ever treated for mental health/substance disorder	**6,717 (35.8)**	6,323 (67.2)	394 (4.2)	<0.01	0.02 (0.02–0.02)	0.02 (0.02–0.03)
Relationship problems/loss						
Any relationship problem/loss	**7,948 (42.4)**	3,726 (39.6)	4,222 (45.1)	<0.01	1.3 (1.2–1.3)	1.3 (1.2–1.4)
Intimate partner problem	**5,098 (27.2)**	2,270 (24.1)	2,828 (30.2)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Perpetrator of interpersonal violence in past month	**414 (2.2)**	131 (1.4)	283 (3.0)	<0.01	2.2 (1.8–2.7)	2.0 (1.6–2.4)
Victim of interpersonal violence in past month	**84 (0.4)**	53 (0.6)	31 (0.3)	<0.05	0.6 (0.4–0.9)	0.8 (0.5–1.2)
Family relationship problem	**1,671 (8.9)**	873 (9.3)	798 (8.5)	NS	0.9 (0.8–1.0)	1.0 (0.9–1.1)
Other relationship problem (nonintimate)	**403 (2.1)**	202 (2.1)	201 (2.1)	NS	1.0 (0.8–1.2)	1.1 (0.9–1.3)
Argument or conflict (not specified)	**2,914 (15.5)**	1,278 (13.6)	1,636 (17.5)	<0.01	1.3 (1.2–1.5)	1.4 (1.3–1.5)
Death of a loved one (any)	**1,497 (8.0)**	826 (8.8)	671 (7.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–0.9)
Nonsuicide death	**1,181 (6.3)**	647 (6.9)	534 (5.7)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Suicide of family or friend	**379 (2.0)**	217 (2.3)	162 (1.7)	<0.01	0.7 (0.6–0.9)	0.8 (0.7–1.0)
Other life stressors						
Any life stressor	**9,171 (48.9)**	4,442 (47.2)	4,729 (50.5)	<0.01	1.1 (1.1–1.2)	1.1 (1.0–1.2)
Recent criminal legal problem	**1,588 (8.5)**	586 (6.2)	1,002 (10.7)	<0.01	1.8 (1.6–2.0)	1.7 (1.5–1.9)
Other legal problem	**748 (4.0)**	378 (4.0)	370 (4.0)	NS	1.0 (0.8–1.1)	1.0 (0.9–1.2)
Physical health problem	**4,179 (22.3)**	2,012 (21.4)	2,167 (23.2)	<0.01	1.1 (1.0–1.2)	1.0 (1.0–1.1)
Job/Financial problem¶¶	**2,941 (16.2)**	1,530 (16.8)	1,411 (15.6)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Eviction or loss of home	**722 (3.8)**	317 (3.4)	405 (4.3)	<0.01	1.3 (1.1–1.5)	1.4 (1.2–1.6)
School problem***	**162 (19.9)**	70 (17.8)	92 (21.9)	NS	1.3 (0.9–1.8)	1.3 (0.9–1.9)
Recent release from an institution†††	**1,412 (7.6)**	941 (10.2)	471 (5.1)	<0.01	0.5 (0.4–0.5)	0.5 (0.4–0.5)
Jail/Prison/Detention facility	**203 (14.4)**	82 (8.7)	121 (25.7)	<0.01	3.6 (2.7–4.9)	4.5 (3.2–6.4)
Hospital	**517 (36.6)**	311 (33.0)	206 (43.7)	<0.01	1.6 (1.3–2.0)	1.3 (1.0–1.7)
Psychiatric hospital/institution	**469 (33.2)**	439 (46.7)	30 (6.4)	<0.01	0.1 (0.1–0.1)	0.1 (0.1–0.1)
Other (includes alcohol/SU treatment facilities)	**223 (15.8)**	109 (11.6)	114 (24.2)	<0.01	2.4 (1.8–3.3)	2.5 (1.8–3.3)

See table footnotes on next page.

Suicidologists regularly state that suicide is not caused by a single factor (*5*); however, suicide prevention is often oriented toward mental health conditions alone with regard to downstream identification of suicidal persons, treatment of mental health conditions, and prevention of reattempts. This study found that approximately half of suicide decedents in NVDRS did not have a known mental health condition, indicating that additional focus on nonmental health factors further upstream could provide important information for a public health approach (*10*). Those without a known mental health condition suffered more from relationship problems and other life stressors such as criminal/legal matters, eviction/loss of home, and recent or impending crises.

Similarly, persons with mental health conditions also often experienced other circumstances such as relationship problems and job/financial or physical health problems that contributed to their suicide. These findings point to the need to both prevent the circumstances associated with the onset of mental health conditions and support persons with known mental health conditions to decrease their risk for poor outcomes (*11*). Two thirds of suicide decedents with mental health conditions had a history of treatment for mental health or substance use disorders,

TABLE 2. (*Continued*) Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Crisis within past or upcoming 2 weeks§§§	**5,525 (29.4)**	2,444 (26.0)	3,081 (32.9)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Intimate partner problem	**1,968 (35.6)**	854 (34.9)	1,114 (36.2)	NS	1.1 (0.9–1.2)	1.1 (0.9–1.2)
Physical health problem	**739 (13.4)**	315 (12.9)	424 (13.8)	NS	1.1 (0.9–1.3)	1.0 (0.8–1.2)
Criminal legal problem	**621 (11.2)**	203 (8.3)	418 (13.6)	<0.01	1.7 (1.5–2.1)	1.6 (1.3–1.9)
Family relationship problem	**430 (7.8)**	212 (8.7)	218 (7.1)	<0.05	0.8 (0.7–1.0)	0.9 (0.7–1.1)
Job problem	**354 (6.4)**	191 (7.8)	163 (5.3)	<0.01	0.7 (0.5–0.8)	0.7 (0.5–0.8)
Suicide event/history						
Left a note	**6,468 (34.5)**	3,182 (33.8)	3,286 (35.1)	NS	1.1 (1.0–1.1)	1.2 (1.1–1.2)
Disclosed suicide intent	**4,405 (23.5)**	2,306 (24.5)	2,099 (22.4)	<0.01	0.9 (0.8–1.0)	0.9 (0.8–0.9)
History of ideation	**5,990 (31.9)**	3,838 (40.8)	2,152 (23.0)	<0.01	0.4 (0.4–0.5)	0.4 (0.4–0.5)
History of attempts	**3,732 (19.9)**	2,770 (29.4)	962 (10.3)	<0.01	0.3 (0.3–0.3)	0.3 (0.3–0.3)

Abbreviations: ADD/ADHD = attention deficit disorder/attention deficit hyperactivity disorder; CI = confidence interval; N/A = not applicable; NS = not significant; OR = odds ratio; PTSD = posttraumatic stress disorder; SU = substance use.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was the reference group.

** Includes decedents with one or more diagnosed current mental health conditions, which are not mutually exclusive. Therefore, sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health conditions.

†† The specific type of mental health condition was calculated only among those with one or more known diagnosed mental health conditions.

§§ Not a diagnosis.

¶¶ Denominator is decedents aged ≥18 years.

*** Denominator is decedents aged 10–18 years.

††† Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.

§§§ Denominator of crisis subgroup is decedents with any crisis within past or upcoming 2 weeks. Crises depicted here represent the most commonly occurring categories.

with approximately half in treatment when they died. This finding suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities, such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. In addition, increased access to behavioral health providers in underserved areas is needed, as is expansion of health care systems that integrate physical and behavioral health, with a priority on suicide prevention and patient safety, especially through care transitions (*12*).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belonging and access to informational, tangible, emotional, and social support; and identifying and better supporting persons at risk (e.g., military veterans, persons with physical/mental health conditions) (*12*). Other strategies include creating protective environments (e.g., reducing access to lethal means among persons at risk for suicide, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for persons with mental health conditions and other life challenges), strengthening access to and delivery of care, supporting family and friends after a suicide, and encouraging the media to follow safe reporting recommendations (*12*). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (*10*).

The findings in this report are subject to at least three limitations. First, in the state-level analysis, rankings for four states (Maryland, Massachusetts, Rhode Island, and Utah) might have been affected by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward) or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml). Finally, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies that include more in-depth interviews with next-of-kin often identify greater attributions to mental health disorders

Summary

What is already known about this topic?

In 2016, nearly 45,000 persons died by suicide in the United States. Mental health conditions are one of several contributors to suicide.

What is added by this report?

During 1999–2016, suicide rates increased in nearly every state, including >30% increases in 25 states. 2015 data from 27 states indicate 54% of suicide decedents were not known to have mental health conditions. Relationship, substance use, health, and job or financial problems are among the other circumstances contributing to suicide.

What are the implications for public health practice?

A comprehensive approach using proven prevention strategies, such as those in CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, can help reach the national goal of reducing the annual suicide rate 20% by 2025.

(*13*); however, many methodological variations across studies exist (*14*). It is likely that some persons without known mental health conditions in the current study were experiencing mental health challenges that were unknown, undiagnosed, or not reported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (*12*) to better understand suicide in their populations, prioritize evidence-based comprehensive suicide prevention, and save lives.

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Conflict of Interest

No conflicts of interest were reported.

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#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



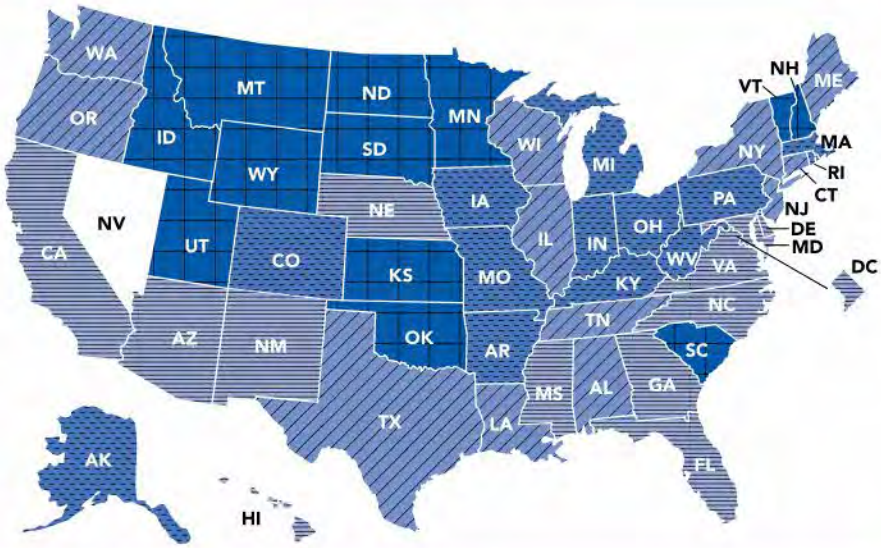
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

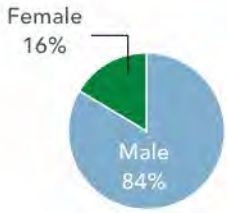


Differences exist among those with and without mental health conditions.

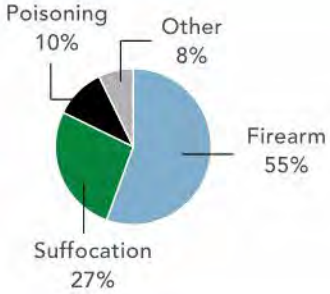
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

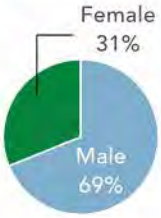


Method

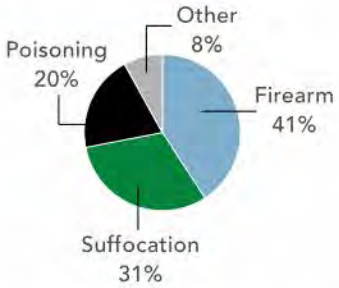


Known mental health conditions

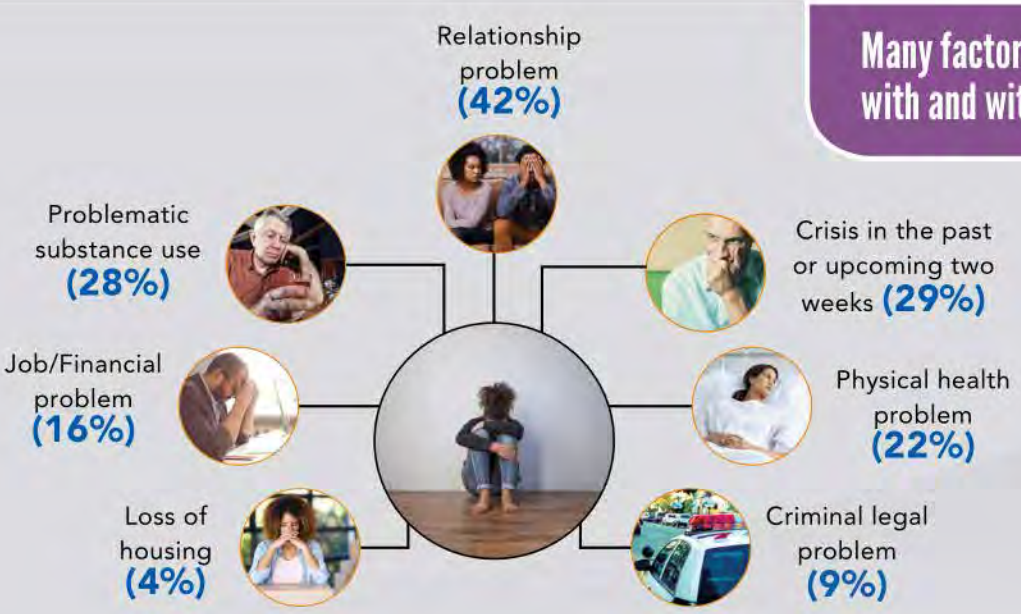
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018

Media Advisory

Embargoed Until 1 p.m. EDT
Thursday, June 7, 2018

Contact: CDC Media Relations
(404) 639-3286

CDC Telebriefing: New *Vital Signs* Report

Nearly 45,000 deaths by suicide in 2016:
What can be done to prevent suicides?

What

According to the latest Vital Signs report, suicide increased in nearly every U.S. state from 1999 through 2016. In addition, suicide rates increased more than 30% in half of states. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death.

Who

CDC Principal Deputy Director Anne Schuchat, MD, RADM, USPHS

When

Thursday, June 7, at 12:00 p.m. ET

Dial-In

Media: 888-795-0855

Non-Media: 800-369-1605

INTERNATIONAL: 1-630-395-0331

PASSCODE: CDC Media

Important Instructions

If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question.

You may queue up at any time. You will hear a tone to indicate your question is pending.

TRANSCRIPT

A transcript of this media availability will be available following the briefing at CDC's web site: www.cdc.gov/media.

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U.S. Department of Health and Human Services

CDC works 24/7 protecting America's health, safety, and security. Whether diseases start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

Press Release

Embargoed until 1:00 pm ET
Thursday, June 7, 2018

Contact: CDC Media Relations
404-639-3286

Suicide rates rising across the U.S.

Comprehensive prevention goes beyond a focus on mental health concerns

Suicide rates have been rising in nearly every state, according to the latest *Vital Signs* report by the Centers for Disease Control and Prevention (CDC). In 2016, nearly 45,000 Americans age 10 or older died by suicide. Suicide is the 10th leading cause of death and is one of just three leading causes that are on the rise.

Suicide is rarely caused by a single factor. Although suicide prevention efforts largely focus on identifying and providing treatment for people with mental health conditions, there are many additional opportunities for prevention.

"Suicide is a leading cause of death for Americans – and it's a tragedy for families and communities across the country," said CDC Principal Deputy Director Anne Schuchat, M.D. "From individuals and communities to employers and healthcare professionals, everyone can play a role in efforts to help save lives and reverse this troubling rise in suicide."

Many factors contribute to suicide

For this *Vital Signs* report, CDC researchers examined state-level trends in suicide rates from 1999-2016. In addition, they used 2015 data from CDC's National Violent Death Reporting System, which covered 27 states, to look at the circumstances of suicide among people with and without known mental health conditions.

Researchers found that more than half of people who died by suicide did *not* have a known diagnosed mental health condition at the time of death. Relationship problems or loss, substance misuse; physical health problems; and job, money, legal or housing stress often contributed to risk for suicide. Firearms were the most common method of suicide used by those with and without a known diagnosed mental health condition.

State suicide rates vary widely

The most recent overall suicide rates (2014-2016) varied four-fold; from 6.9 per 100,000 residents per year in Washington, D.C. to 29.2 per 100,000 residents in Montana.

Across the study period, rates increased in nearly all states. Percentage increases in suicide rates ranged from just under 6 percent in Delaware to over 57 percent in North Dakota. Twenty-five states had suicide rate increases of more than 30 percent.

Wide range of prevention activities needed

The report recommends that states take a comprehensive public health approach to suicide prevention and address the range of factors contributing to suicide. This requires coordination and cooperation from

every sector of society: government, public health, healthcare, employers, education, media and community organizations.

To help states with this important work, in 2017 CDC released a technical package on suicide prevention that describes strategies and approaches based on the best available evidence. This can help inform states and communities as they make decisions about prevention activities and priorities.

Everyone can help prevent suicide:

- Learn the warning signs of suicide to identify and appropriately respond to people at risk. Find out how this can save a life by visiting: www.BeThe1to.com
- Reduce access to lethal means – such as medications and firearms – among people at risk of suicide.
- Contact the National Suicide Prevention Lifeline for help: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org

The media can avoid increasing risk when reporting on suicide by:

- Following and sharing recommendations available at www.reportingonsuicide.org (for example, avoiding dramatic headlines or explicit details on suicide methods);
- Providing information on suicide warning signs and suicide prevention resources; and
- Sharing stories of hope and healing.

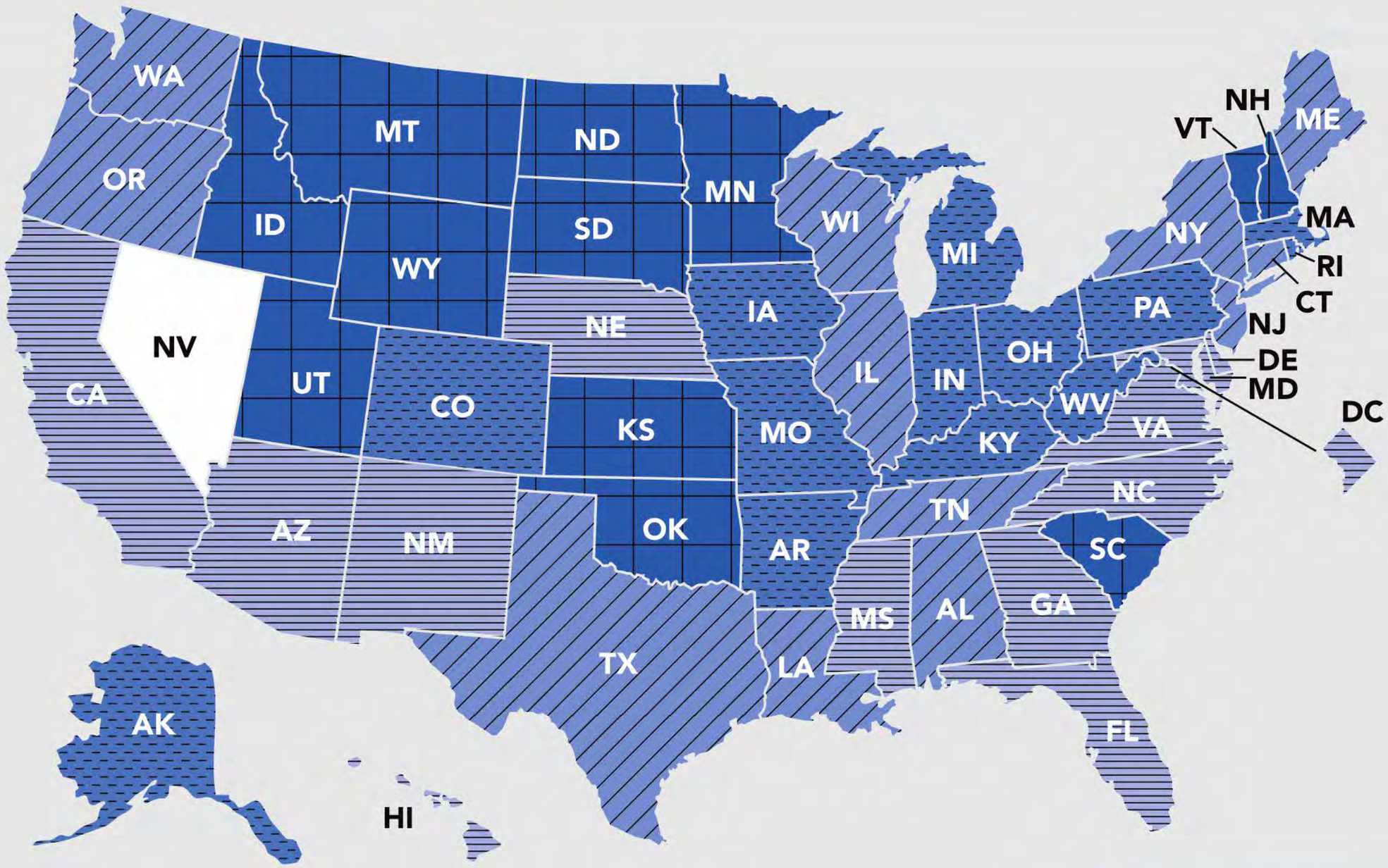
Vital Signs is a CDC report that typically appears on the first Tuesday of the month as part of the CDC journal *Morbidity and Mortality Weekly Report*. The report provides the latest data and information on key health indicators, and what can be done to drive down these health threats.

###

U.S. Department of Health and Human Services

CDC works 24/7 protecting America's health, safety, and security. Whether diseases start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System.*

CDC Vitalsigns™

https://www.cdc.gov/vitalsigns/suicide

CS292322-C

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: 25 May 2018 19:26:53 +0000
To: Holland, Kristin (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Conversation with Holland, Kristin (CDC/ONDIEH/NCIPC)

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:22 AM:
now i'm about to get in big trouble!
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:22 AM:
oh no, why?!
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:23 AM:
so, i mentioned the media recs for reporting on mass shootings to marie ballman, and she looked them up and has now emailed me twice (b/c i didn't respond to the first email) to ask how you and i were involved in developing them and when they were cleared! (facepalm)
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:24 AM:
F---
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:24 AM:
exactly
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:25 AM:
so cdc is listed on them
specifically
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:25 AM:
yeah
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:25 AM:
i'm totally getting fired! It's been a good 8 years...
our names aren't on them are they?!
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:25 AM:
ha
whatever, this one is totally on me
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:26 AM:
why?
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:26 AM:
b/c i'm the one who said i would submit them for clearance and i completely forgot to and then next thing we knew, they were published!
This consensus project was led by SAVE and included national and international experts from AFSP, the CDC, Columbia University, IASP Media Task Force, JED, NAMI--NH, SPRC, and multiple media industry experts.
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:27 AM:
Oh. I didn't remember that.
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:27 AM:
f*ck
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:27 AM:
ugh!!!!!!!!!
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:27 AM:
i even sent her the link. wtf is wrong with me??
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:27 AM:
lol. you are bold!
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:28 AM:
i should have just 'forgotten' to send it to her
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:28 AM:
well if she asked i'm pretty sure she'd keep reminding you
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:28 AM:

yeah, she had already reminded me once
lol

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:28 AM:
so what are we going to do?

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:29 AM:
sh*t. i don't know

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:29 AM:
Can we tell Dan to just take cdc off!?

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:30 AM:
ok, so her question says 'what capacity did we contribute' - which i can say we attended phone calls and provided links to empirical research on suicide contagion
and we suggested revisions as necessary to the docs (not sure whether i should say that)
but the 2nd question was 'what was the review/clearance process? was it similar/different from DVP involvement with the suicide reporting recs?'
i wasn't around for that, so i don't know what that process was, but they probably actually followed the rules and got that cleared

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:31 AM:
right

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:31 AM:
you're right - it has been a nice 8 years
maybe i can get a job as the receptionist at the twins' daycare. they're hiring.

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:32 AM:
smh. well, maybe tell her we'll get them to take cdc off.
ha!
You wouldn't last long there.

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:32 AM:
haaaaaaa - you're right about that

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:32 AM:
i'm thinking about going to work for the action alliance or sprc or afsp or wherever

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:33 AM:
well that would be a logical step

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:33 AM:
heck, maybe dan will hire us!

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:33 AM:
you could take michelle cornette's place from wherever she's moving from

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:33 AM:
that's hilarious. oh btw, remind me to tell you something.
about her

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:33 AM:
ha! i'm sure dan is like 'um, kristin never responds to emails. i'm not hiring her'

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:33 AM:
i know, i don't either. he probably hates us.
ok but seriously, how can i help?

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:34 AM:
i don't know. marie is on the list of people who hate me right now

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:35 AM:
maybe go buy her a present and tell her you're really sorry and to please have mercy. oh and get a card so i can sign it too.
ugh

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:35 AM:
haaaaa
well she obvs wants an answer now

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:36 AM:
sigh...
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:36 AM:
think i should call her and be like, so i just realized there was an issue with clearance...
in that we never got it cleared. lol
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:37 AM:
yeah, maybe tell her the reason you sent her the link is as a confession, there was a clearance issue, there wasn't any.
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:37 AM:
ughhh, it says all the same things as the suicide recs basically
hahaha
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:38 AM:
do you want to set up a meeting or does that make it too obvious we're afraid?!
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:38 AM:
so, what if i call her and be like 'i didn't miss your first email, but i was looking into it to see what process we had gone through for clearance (b/c it has been a really long time since we worked on it)
and i realized that it must have fallen through the cracks and not gotten cleared
and then i can say that i can contact dan and have CDC taken off of it, or could we clear it after the fact and keep CDC on it? (although that introduces a whole slew of issues b/c we obvs can't ask dan to change anything now). i don't even know how easy it would be to ask him to take our name off
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:43 AM:
Yeah, i was thinking about post-hoc clearance. Do you think Dan would be amenable to changes at all?
Maybe he could call them revised guidelines and they'd get more media attention???
how long have they been out?
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:43 AM:
i don't know
it says copyright 2017
i think they came out in like jan 2017
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:43 AM:
ok.
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:44 AM:
so i could contact marie and say all that stuff and say i can contact dan and ask if he would be amenable to revisions, if not, just take CDC name off?
but we can still point people to the recommendations, right?
even if they're not 'ours'
ok, i'm going to call her now
wish me luck!
phew - no answer. i'll try again in a bit
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:49 AM:
oh sorry i missed my chance for good luck. Good luck for next time!!
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:49 AM:
haha
how do i get myself into these messes??
i suppose it has something to do with my laissez faire attitude about clearance
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:49 AM:
b/c you have an insatiable desire to be of service to the public! :)
Holland, Kristin (CDC/ONDIEH/NCIPC) 9:50 AM:
ah, yes, that's it!
Stone, Deborah (CDC/ONDIEH/NCIPC) 9:50 AM:
better than your explanation!
same goes for me.

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:50 AM:
at least you follow the rules most of the itme
you err on the side of the caution
and i usually throw caution to the wind! lol
i reread the recommendations, and there's nothing bad in there

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:55 AM:
ok that's good and i'm not sure about your assessment. i mean i guess i try to follow the rules!

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:57 AM:
at least you always think about what others will think
in a caring, thoughtful way, i mean
not like you're caught up in other people's opinions

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:57 AM:
yes but only in certain contexts--depends on who the others are and whether they scare me.

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:57 AM:
exactly
lol

Stone, Deborah (CDC/ONDIEH/NCIPC) 9:58 AM:
ok, getting on a call in a min. let me know if you want me to join a call or anything. i'm sure i will be involved before too long.

Holland, Kristin (CDC/ONDIEH/NCIPC) 9:59 AM:
:(i'm going to try to keep your name out of it

Stone, Deborah (CDC/ONDIEH/NCIPC) 10:00 AM:
well at this point it doesn't really matter!
b/c i'm in hot water already

Holland, Kristin (CDC/ONDIEH/NCIPC) 10:02 AM:
well, i'm trying to keep you out of more. i don't even think yours is as bad as this, actually. you had that paper cleared by a million different people!

Stone, Deborah (CDC/ONDIEH/NCIPC) 10:06 AM:
hmm...

Stone, Deborah (CDC/ONDIEH/NCIPC) 11:28 AM:
Anything new?

11:28 AM The following can't receive IMs right now: Holland, Kristin (CDC/ONDIEH/NCIPC)
Anything new?

Holland, Kristin (CDC/ONDIEH/NCIPC) 12:31 PM:
the convo with marie went well
the plan now is that she's going to check with leslie dorigo to see how to move forward, but she doesn't want me to contact dan until we decide exactly what to do. she wants us to go ahead and get it cleared though, so that we can reference it when the SAVD paper comes out
and i put it all on me, btw, i was like 'i totally remember that there was so much going on at the time - i recall it was when you were in NY with your mom, we were making final revisions to the TP, we were working on this and a million other things, so it just slipped through the cracks
and i told her i was the one who was supposed to get it cleared
and then i was like 'it's been nice working here for 9 years, so at least i'll have that when they fire me'
and she was like, 'no please - this is the least of my worries right now'
she seemed to think it wasn't a HUGE deal

Stone, Deborah (CDC/ONDIEH/NCIPC) 12:42 PM:
Oh thank goodness!!!
Dodged that bullet
i feel bad for Tom. I think this nchs thing isn't good.

Holland, Kristin (CDC/ONDIEH/NCIPC) 12:43 PM:
which nchs thing?

oh shit
i just see your email now
that's the one i emailed tom about and said 'i would have been more concerned about this b/c it seems quite similar to our study - except they go into a more granular level of detail'
ugh

Stone, Deborah (CDC/ONDIEH/NCIPC) 12:46 PM:

i know, i remember that was the one!!
can you help me with a q&A possibly?

Holland, Kristin (CDC/ONDIEH/NCIPC) 12:47 PM:

sure
about that study in particular, or something else?

Stone, Deborah (CDC/ONDIEH/NCIPC) 12:48 PM:

yeah about that study. i will try and read it today but just don't know i'm going to get to it. if you don't have time, i can just do it over the weekend.

Holland, Kristin (CDC/ONDIEH/NCIPC) 12:48 PM:

i actually put something about it in the QA already
but i put it under 'recent cdc research'
if you want me to come up with a question like 'how is this study different from NCHS?' i can do that

Stone, Deborah (CDC/ONDIEH/NCIPC) 12:52 PM:

I thought we probably had something in there from our mmwr. Ok, that question is good. Thanks.

Holland, Kristin (CDC/ONDIEH/NCIPC) 12:53 PM:

ok

Holland, Kristin (CDC/ONDIEH/NCIPC) 1:42 PM:

ok, so she talked to leslie, and leslie agrees that it would be good to have our name on the document so we can disseminate it, but we obvs need to get it cleared
so i'm going to reach out to dan to see if i can set up a call with him to discuss this. do you want to be on the call? do you want me to cc you on the email? or do you want to be completely left out of this (i don't blame you if you do)

Stone, Deborah (CDC/ONDIEH/NCIPC) 3:26 PM:

i'm happy to be on the call.
that sounds good

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 22 May 2018 14:20:02 +0000
To: Bruce, Crystal (CDC/OPHPR/OD)
Cc: Black, Erin (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC)
Subject: DC Letter
Attachments: DC_V1_5.15.18.13.02pm_CB_MRB_DS MRC TS DS_rev ds.docx
Importance: High

Hi Crystal,
The DC letter needs to be updated further. The title of the MMWR was incorrect, yikes!
I hope it's not too late. May be good for us to touch based about all the products and their status.
It would be good to get the whole list of all the products and where they are and where they need to go and by when.
Deb

Deb Stone, ScD, MSW, MPH
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CDC's Injury Center
Preventing Injuries and Violence Through Science and Action

Review Tracker

- NCIPC OC Leslie Dorigo:
- DVP ADS Tom Simon: 4/24/18
- DVP Policy Malia Richmond-Crum: 4/23/18
- DVP SME Deb Stone: 4/19/18, 4/24/18
- DVP HCET Marie Ballman: 4/17/2018

Comment [zaf9]: Title has changed. Trends in State Suicide Rates—United States, 1999-2016 and Circumstances Contributing to Suicide—27 States, 2015

Comment [BC(]: NOTE TO REVIWERS: DVP will add more specific activities to this paragraph off-line and insert it before Friday.

Dear Colleague:

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and ~~others~~ partners working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Tuesday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Web page to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June12, 2016, at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Thank you for your support.

Debra Houry, MD, MPH
Director
National Center for Injury Prevention and Control

James A. Mercy, PhD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 26 Feb 2018 22:31:16 +0000
To: Caine, Eric (Eric_Caine@URMC.Rochester.edu);jarrod.hindman@state.co.us;Reed, Jerry
Subject: AJPH Opinion Editorial
Attachments: FINAL OD Planning Document - Suicide 9-29-2017 rev.docx

Hi Guys,

As you may have heard from me? others? CDC is releasing a *Vital Signs* on Suicide on June 5th. This is a really high profile/high impact publication. It includes a website, MMWR, Fact Sheet, Social Media messages, press release, telebriefing by Acting CDC Director and a Town Hall Meeting (We already have on record that the Surgeon General *may* participate in the telebriefing). Vital Signs sometimes also include an accompanying commentary in a peer reviewed journal. What does this have to do with you? I know you are probably tired of being singled out for all of your great work and perspectives…(sorry!) but would the three of you or some combination of you do us the honor of writing an opinion editorial (1200 words, 7 references,) for us in AJPH about comprehensive suicide prevention and CO efforts [we can refine later but for purposes here, this is the topic]? I'm happy to set up a call to discuss but in the meantime, please see attached Vital Signs description with preliminary results (Please do not distribute or otherwise use or I'll probably be fired). Also see recent Vital Signs (on opioids) and the companion commentary. Also, editorial is due to AJPH **April 5th**!! So it's coming right up. Oy.

Look forward to hearing of your interest and thoughts.

Deb

Deb Stone, ScD, MSW, MPH
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Suicide Prevention
CDC Vital Signs (Proposed release: June 5, 2018)

The Problem: More than 44,000 lives are lost every year in the U.S. to suicide. More than half of these occur among adults in the prime of their lives, ages 35-64. Between 2000 and 2015, suicide rates in the U.S. increased by about 28%, while most other leading causes of death declined. Suicide and non-fatal attempts cost more than $69 billion annually in direct medical and work loss costs. Decades of research have shown that suicide is a preventable public health problem. To help states make greater use of the best available evidence for suicide prevention, the CDC recently released *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*. This *Vital Signs* is an important step toward raising awareness about the need and the opportunity for suicide prevention.

Proposed Vital Signs Approach to Data: The proposed *Vital Signs* will use data from the *National Vital Statistics System* (NVSS, 1999-2016) and *National Violent Death Reporting System* (NVDRS, 2015). The trends in rates in the U.S. overall and by state and sex, will be reported. Changes in state rankings over time will also be reported. Preliminary results indicate that rates have increased in 29 states by 25% or more over these 18 years. To help the reader fully understand the factors influencing suicide risk, the report will also summarize suicide circumstances using the 2015 NVDRS. We will compare suicide risk factors among people with and without mental health problems to describe the social and environmental factors contributing to suicide.

Recommendations to be made: The gold standard of suicide prevention is a population-based public health approach rather than solely a mental health approach that seeks to identify and treat people with mental health problems. The need for a public health approach was announced in the 1999 *Surgeon General's Call to Action to Prevent Suicide,* but barriers to this approach continue today. CDC recently released a technical package for suicide prevention that includes the best available evidence for suicide prevention. The technical package describes seven strategies: strengthening economic supports, strengthening access and delivery of suicide care, creating protective environments, promoting connectedness, teaching coping and problem-solving skills, identifying and supporting people at risk, and lessening harms and preventing future risk. These strategies are designed to work synergistically at the population level. Examples of specific programs, practices, and policies for each strategy are described in the technical package. Each approach was rigorously evaluated and found to have beneficial effects on suicide or suicide risk and protective factors.

Fit with current program: The NCIPC Director has made suicide prevention a top priority because of the fast-growing mortality and the existence of evidence-based prevention strategies. The NCIPC technical package on suicide prevention describes evidence-based policies, programs, and practices for comprehensive action. In addition, NCIPC has developed a strategic plan to focus our suicide prevention efforts, and the proposed *Vital Signs* is an important early part of this plan.

Newsworthiness: This is the first state-based analysis of increasing suicide rates across all 50 states and Washington, D.C, over 18 years, and results will be mapped. The reader will be informed about the most important factors associated with suicide, including situational factors such as job, financial, substance abuse, relationship, and legal problems, that are contributing to risk for suicide among those with and without mental health problems. Preventive solutions will be provided using a comprehensive population-based approach to prevention based on policy, programs, and practices described in the Suicide Prevention Technical Package.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 13:36:54 +0000
To: McKeon, Richard (SAMHSA/CMHS);Pearson, Jane L (NIH/NIMH) [E];John Draper
Subject: Embargoed until 1pm June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
Attachments: MMWR_Vital Signs_ Suicide_6.7.2018_article.pdf, MMWR Supplemental table__VS Suicide_ 6.7.2018_final.pdf, FACT SHEET_Vital Signs_June_2018_Suicide_Final_WEB.pdf

Dear Richard, Jane, and John,
Circling back to you after many months. Our Vital Signs report is being released today at 1:00. I want to thank you for your input early on and I look forward to discussing on Tuesday's Federal Partner call. I hope this report will bring greater attention to the problem of suicide, the multiple factors associated with suicide, and how we can prevent suicide. This vital signs took a lot of CDC resources and it is heartening to know that the issue, our issue, was taken up. This is a good sign and I hope it will have a very positive impact for the field. We sure need it.
Best wishes,
Deb
******

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Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 67 / No. 22
June 8, 2018

Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

Deborah M. Stone, ScD[1]; Thomas R. Simon PhD[1]; Katherine A. Fowler, PhD[1]; Scott R. Kegler, PhD[2]; Keming Yuan, MS[1]; Kristin M. Holland, PhD[1]; Asha Z. Ivey-Stephenson, PhD[1]; Alex E. Crosby, MD[1]

Abstract

Introduction: Suicide rates in the United States have risen nearly 30% since 1999, and mental health conditions are one of several factors contributing to suicide. Examining state-level trends in suicide and the multiple circumstances contributing to it can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among persons aged ≥10 years, by state and sex, across six consecutive 3-year periods (1999–2016), were assessed using data from the National Vital Statistics System for 50 states and the District of Columbia. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health conditions.

Results: During 1999–2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases >30%. Rates increased significantly among males and females in 34 and 43 states, respectively. Fifty-four percent of decedents in 27 states in 2015 did not have a known mental health condition. Among decedents with available information, several circumstances were significantly more likely among those without known mental health conditions than among those with mental health conditions, including relationship problems/loss (45.1% versus 39.6%), life stressors (50.5% versus 47.2%), and recent/impending crises (32.9% versus 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states during 1999–2016. Various circumstances contributed to suicides among persons with and without known mental health conditions.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends and family members in the aftermath of a suicide.

INSIDE

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Continuing Education examination available at https://www.cdc.gov/mmwr/cme/conted_info.html#weekly.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Introduction

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (*1*). From 1999 to 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (*2,3*). Suicide rates have also increased among persons in all age groups <75 years, with adults aged 45–64 having the largest absolute rate increase (from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (232,108) during the same period (*1,3*). Suicide is the tenth leading cause of death and is one of just three leading causes that are increasing (*1,4*). In addition, rates of emergency department visits for nonfatal self-harm, a main risk factor for suicide, increased 42% from 2001 to 2016 (*1*). Together, suicides and self-harm injuries cost the nation approximately $70 billion per year in direct medical and work loss costs (*1*).

The National Strategy for Suicide Prevention (*5*) calls for a public health approach to suicide prevention with efforts spanning multiple levels (individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is determined by multiple factors. Despite this call to action, suicide prevention largely focuses on identifying and referring suicidal persons to mental health treatment and preventing reattempts (*6*). In addition to mental health conditions and prior suicide attempts, other contributing circumstances include social and economic problems, access to lethal means (e.g., substances, firearms) among persons at risk, and poor coping and problem-solving skills (*5*). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them can help reach the national goal, established by the National Action Alliance of Suicide Prevention and the American Foundation for Suicide Prevention, of reducing the annual suicide rate 20% by 2025 (*7*). To assist states in achieving this goal, CDC analyzed state-specific trends in suicide rates and assessed the multiple contributing factors to suicide; this report presents options for strategies to include in comprehensive suicide prevention efforts that are based on the best available evidence.

Methods

Suicide rates were analyzed for persons aged ≥10 years because determining suicidal intent in younger children can be difficult (*8*). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases, Tenth Revision,* underlying-cause-of death codes X60–X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive 3-year aggregate periods spanning 1999–2016 (1999–2001; 2002–2004; 2005–2007; 2008–2010; 2011–2013; and 2014–2016). Rate estimates were age-adjusted to the U.S. 2000 standard population and expressed

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Suggested citation: [Author names; first three, then et al., if more than six.] [Report title]. MMWR Morb Mortal Wkly Rep 2018;67:[inclusive page numbers].

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per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same 3-year data aggregates, employing weighted least-squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes.

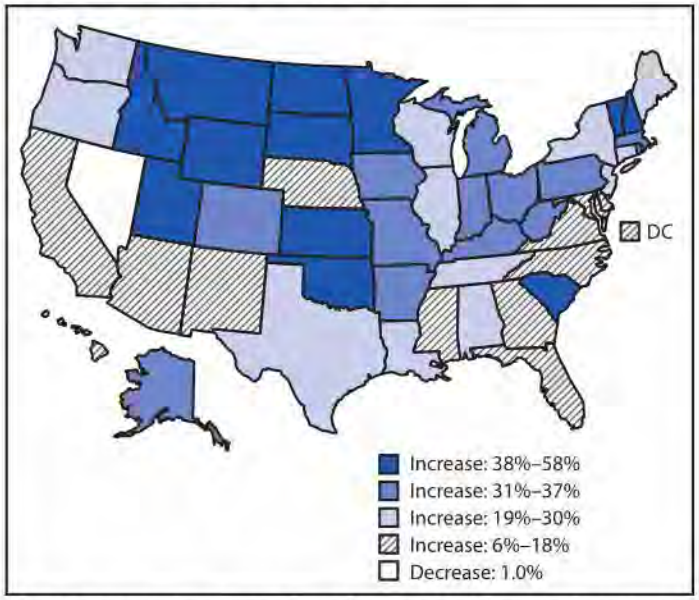
Characteristics of persons aged ≥10 years who died by suicide, with and without known mental health conditions, and the circumstances surrounding the suicides were compared in the 27 states* with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines mental health conditions as disorders and syndromes listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*9*), with the exception of problematic alcohol use and other substance use that are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. A range of circumstances (relationship problems, life stressors, and recent or impending crises) have been identified as potential risk factors for suicide in NVDRS. Circumstances captured are those identified as contributing to suicide in coroner/medical examiner or law enforcement reports, which reflect information provided by family and friends at the time of death. Decedents could have experienced multiple circumstances. Decedents with and without known mental health conditions were compared using chi-square tests. Logistic regression analyses were used to estimate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), controlling for sex, age group, and race/ethnicity.

Results

The most recent overall suicide rates (representing 2014–2016) varied fourfold, from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Across the study period, rates increased in all states except Nevada (where the rate was consistently high throughout the study period), with absolute increases ranging from 0.8 per 100,000 (Delaware) to 8.1 (Wyoming). Percentage increases in rates ranged from 5.9% (Delaware) to 57.6% (North Dakota), with increases >30% observed in 25 states (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785) (Figure).

Modeled suicide rate trends indicated significant increases in 44 states, among males (34 states) and females (43 states), as well as for the United States overall (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Nationally, the model-estimated average annual percentage change for the overall suicide rate was an increase of 1.5%. By sex, estimated national rate trends further indicated significant average annual percentage change increases for males (1.1%) and females (2.6%) (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785).

FIGURE. Percent change in annual suicide rate,* by state — United States, from 1999–2001 to 2014–2016



* Per 100,000 population, age-adjusted to the 2000 U.S. standard population.

Suicide decedents without known mental health conditions (11,039; 54.0%) were compared with those with known mental health conditions (9,407; 46.0%) for 27 states. Whereas decedents were predominantly male (76.8%) (Table 1) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely to be male (83.6% versus 68.8%; odds ratio [OR] = 2.3, 95% CI = 2.2–2.5) and belong to a racial/ethnic minority (OR range = 1.2–2.0). Suicide decedents without known mental health conditions also had significantly higher odds of perpetrating homicide followed by suicide (aOR = 2.9, 95% CI = 2.2–3.8). Among decedents aged ≥18 years, 20.1% of those without known mental health conditions and 15.3% of those with mental health conditions had previously served in the U.S. military or were serving at the time of death.

Whereas firearms were the most common method of suicide overall (48.5%), decedents without known mental health conditions were more likely to die by firearm (55.3%) and less likely to die by hanging/strangulation/suffocation (26.9%) or poisoning (10.4%) than were those with known mental health conditions (40.6%, 31.3%, and 19.8%, respectively). These differences remained significant in the adjusted models.

Toxicology testing was less likely to be performed for decedents without known mental health conditions. Among those with toxicology results, decedents without known mental health

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

TABLE 1. Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	**15,702 (76.8)**	6,469 (68.8)	9,233 (83.6)	<0.01	2.3 (2.2–2.5)	NA
Female	**4,744 (23.2)**	2,938 (31.2)	1,806 (16.4)	<0.01	0.4 (0.4–0.5)	NA
Age group (yrs)**						
10–24	**2,804 (13.7)**	1,211 (12.9)	1,593 (14.4)	<0.01	1.1 (1.1–1.2)	NA
25–44	**6,456 (31.6)**	3,036 (32.3)	3,420 (31.0)	<0.05	0.9 (0.9–1.0)	NA
45–64	**7,718 (37.7)**	3,820 (40.6)	3,898 (35.3)	<0.01	0.8 (0.8–0.8)	NA
≥65	**3,468 (17.0)**	1,340 (14.2)	2,128 (19.3)	<0.01	1.4 (1.3–1.5)	NA
Race/Ethnicity						
White, non-Hispanic	**17,102 (83.6)**	8,165 (86.8)	8,937 (81.0)	<0.01	0.6 (0.6–0.7)	NA
Black, non-Hispanic	**1,228 (6.0)**	411 (4.4)	817 (7.4)	<0.01	1.7 (1.5–2.0)	NA
American Indian/Alaska Native, non-Hispanic	**378 (1.8)**	112 (1.2)	266 (2.4)	<0.01	2.0 (1.6–2.6)	NA
Asian, non-Hispanic	**576 (2.8)**	235 (2.5)	341 (3.1)	<0.05	1.2 (1.1–1.5)	NA
Hispanic	**1,096 (5.4)**	463 (4.9)	633 (5.7)	<0.05	1.2 (1.0–1.3)	NA
Other	**66 (0.3)**	21 (0.2)	45 (0.4)	<0.05	1.8 (1.1–3.1)	NA
Extended demographics						
Ever served in military††	**3,429 (17.8)**	1,354 (15.3)	2,075 (20.1)	<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	**240 (1.2)**	104 (1.1)	136 (1.3)	NS	1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident type						
Single suicide	**20,063 (98.2)**	9,318 (99.1)	10,745 (97.4)	<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	**319 (1.6)**	64 (0.7)	255 (2.3)	<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	**64 (0.3)**	25 (0.3)	39 (0.4)	NS	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	**9,909 (48.5)**	3,821 (40.6)	6,088 (55.3)	<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	**5,907 (28.9)**	2,940 (31.3)	2,967 (26.9)	<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	**3,003 (14.7)**	1,861 (19.8)	1,142 (10.4)	<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	**1,021 (34.0)**	666 (35.8)	355 (31.1)	<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	**944 (31.4)**	608 (32.7)	336 (29.4)	NS	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	**800 (26.6)**	644 (34.6)	156 (13.7)	<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	**624 (20.8)**	468 (25.1)	156 (13.7)	<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	**219 (7.3)**	195 (10.5)	24 (2.1)	<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	**1,595 (7.8)**	780 (8.3)	815 (7.4)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)

See table footnotes on next page.

conditions were less likely to test positive for any substance overall (aOR = 0.8, 95% CI = 0.7–0.8), including opioids (aOR = 0.90, 95% CI = 0.81–0.99), but were more likely to test positive for alcohol (aOR = 1.2, 95%, CI = 1.1–1.3).

Information on circumstances surrounding suicide were available for all decedents with mental health conditions (9,407) and approximately 85% of those without known mental health conditions (9,357) in 27 states (Table 2). Persons without known mental health conditions were less likely to have any problematic substance use (aOR = 0.7, 95% CI = 0.7–0.8) than were persons with known mental health conditions. Whereas two thirds of decedents with known mental health conditions had a history of mental health or substance use treatment (67.2%), just over half (54.0%) were in treatment at the time of death.

Decedents without known mental health conditions had a significantly higher likelihood of any relationship problem/loss (45.1%) than did those with known mental health conditions (39.6%), specifically intimate partner problems (30.2% versus 24.1%), arguments/conflicts (17.5% versus 13.6%), and perpetrating interpersonal violence in the past month (3.0% versus 1.4%). Decedents without known mental health conditions were also more likely than were those with known mental health conditions to have experienced any life stressors (50.5% versus 47.2%) such as recent criminal legal problems (10.7% versus 6.2%) or eviction/loss of home (4.3% versus 3.4%) and were more likely to have had a recent or impending (within the preceding or upcoming 2 weeks, respectively) crisis (a current or acute event thought to contribute to the suicide) (32.9% versus 26.0%). All of these differences remained significant in the adjusted models. Physical health problems and job/financial problems were commonly contributing stressors among both persons without mental health conditions (23.2% and 15.6%, respectively) and those with mental health conditions (21.4%

TABLE 1. (*Continued*) Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Toxicology results						
Any toxicology testing	**13,317 (65.1)**	6,658 (70.8)	6,659 (60.3)	<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	**9,913 (74.4)**	5,192 (78.0)	4,721 (70.9)	<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected* **						
Alcohol						
Tested	**10,950 (53.6)**	5,409 (57.5)	5,541 (50.2)	<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	**4,442 (40.6)**	2,115 (39.1)	2,327 (42.0)	<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	**8,554 (41.8)**	4,258 (45.3)	4,296 (38.9)	<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	**2,279 (26.6)**	1,238 (29.1)	1,041 (24.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	**8,124 (39.7)**	4,226 (44.9)	3,898 (35.3)	<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	**2,464 (30.3)**	1,639 (38.8)	825 (21.2)	<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	**7,978 (39.0)**	3,866 (41.1)	4,112 (37.2)	<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	**499 (6.3)**	216 (5.6)	283 (6.9)	<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	**7,615 (37.2)**	3,696 (39.3)	3,919 (35.5)	<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	**736 (9.7)**	376 (10.2)	360 (9.2)	NS	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	**6,569 (32.1)**	3,127 (33.2)	3,442 (31.2)	<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	**1,471 (22.4)**	710 (22.7)	761 (22.1)	NS	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	**5,425 (26.5)**	3,103 (33.0)	2,322 (21.0)	<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	**2,214 (40.8)**	1,735 (55.9)	479 (20.6)	<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviations: CI = confidence interval; NA = not adjusted; NS = not significant; OR = odds ratio.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology testing.

*** Denominator for each positive group is the number tested for the substance in that group.

and 16.8%, respectively). Similarly, among all persons with recent crises, intimate partner problems were the most common types and did not differ by group.

Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR = 0.5, 95% CI = 0.4–0.5). Among those recently released, decedents without known mental health conditions were significantly more likely than decedents with mental health conditions to have been released from a correctional facility (25.7% versus 8.7%), hospital (43.7% versus 33.0%), or other facility, such as an alcohol/substance use treatment facility (24.2% versus 11.6%). Among decedents with known mental health conditions who were recently released from an institution, 46.7% were released from psychiatric facilities.

Decedents without known mental health conditions were significantly less likely to have a history of suicidal ideation (23.0%) or prior suicide attempts (10.3%) compared with those with known mental health conditions (40.8% and 29.4%, respectively). Suicide intent was disclosed by 22.4% and 24.5% of persons without and with known mental health conditions, respectively.

Conclusions and Comments

During 1999–2016, suicide rates increased significantly in 44 states, and 25 states experienced increases >30%. Rates increased significantly among males in 34 states, and females in 43 states. Additional research into the specific causes of these trends is needed. Data from the 27 states participating in NVDRS provide important insight into circumstances surrounding suicide and can help states identify prevention priorities.

TABLE 2. Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	**18,764 (91.8)**	9,407 (100)	9,357 (84.8)	<0.01	N/A	N/A
Mental health						
Any current diagnosed mental health condition**						
Depression/Dysthymia	—††	7,076 (75.2)	N/A	N/A	N/A	N/A
Anxiety disorder	—††	1,579 (16.8)	N/A	N/A	N/A	N/A
Bipolar disorder	—††	1,431 (15.2)	N/A	N/A	N/A	N/A
Schizophrenia	—††	509 (5.4)	N/A	N/A	N/A	N/A
PTSD	—††	424 (4.5)	N/A	N/A	N/A	N/A
ADD/ADHD	—††	226 (2.4)	N/A	N/A	N/A	N/A
Not specified	—††	760 (8.1)	N/A	N/A	N/A	N/A
Current depressed mood§§	**7,038 (37.5)**	3,962 (42.1)	3,076 (32.9)	<0.01	0.7 (0.6–0.7)	0.7 (0.6–0.7)
Problematic substance use						
Any	**5,319 (28.3)**	2,976 (31.6)	2,343 (25.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Alcohol	**3,268 (17.4)**	1,862 (19.8)	1,406 (15.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Other	**3,084 (16.4)**	1,768 (18.8)	1,316 (14.1)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Treatment						
Current mental health/substance use treatment	**5,141 (27.4)**	5,077 (54.0)	64 (0.7)	<0.01	0.01 (0.01–0.01)	0.01 (0.01–0.01)
Ever treated for mental health/substance disorder	**6,717 (35.8)**	6,323 (67.2)	394 (4.2)	<0.01	0.02 (0.02–0.02)	0.02 (0.02–0.03)
Relationship problems/loss						
Any relationship problem/loss	**7,948 (42.4)**	3,726 (39.6)	4,222 (45.1)	<0.01	1.3 (1.2–1.3)	1.3 (1.2–1.4)
Intimate partner problem	**5,098 (27.2)**	2,270 (24.1)	2,828 (30.2)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Perpetrator of interpersonal violence in past month	**414 (2.2)**	131 (1.4)	283 (3.0)	<0.01	2.2 (1.8–2.7)	2.0 (1.6–2.4)
Victim of interpersonal violence in past month	**84 (0.4)**	53 (0.6)	31 (0.3)	<0.05	0.6 (0.4–0.9)	0.8 (0.5–1.2)
Family relationship problem	**1,671 (8.9)**	873 (9.3)	798 (8.5)	NS	0.9 (0.8–1.0)	1.0 (0.9–1.1)
Other relationship problem (nonintimate)	**403 (2.1)**	202 (2.1)	201 (2.1)	NS	1.0 (0.8–1.2)	1.1 (0.9–1.3)
Argument or conflict (not specified)	**2,914 (15.5)**	1,278 (13.6)	1,636 (17.5)	<0.01	1.3 (1.2–1.5)	1.4 (1.3–1.5)
Death of a loved one (any)	**1,497 (8.0)**	826 (8.8)	671 (7.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–0.9)
Nonsuicide death	**1,181 (6.3)**	647 (6.9)	534 (5.7)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Suicide of family or friend	**379 (2.0)**	217 (2.3)	162 (1.7)	<0.01	0.7 (0.6–0.9)	0.8 (0.7–1.0)
Other life stressors						
Any life stressor	**9,171 (48.9)**	4,442 (47.2)	4,729 (50.5)	<0.01	1.1 (1.1–1.2)	1.1 (1.0–1.2)
Recent criminal legal problem	**1,588 (8.5)**	586 (6.2)	1,002 (10.7)	<0.01	1.8 (1.6–2.0)	1.7 (1.5–1.9)
Other legal problem	**748 (4.0)**	378 (4.0)	370 (4.0)	NS	1.0 (0.8–1.1)	1.0 (0.9–1.2)
Physical health problem	**4,179 (22.3)**	2,012 (21.4)	2,167 (23.2)	<0.01	1.1 (1.0–1.2)	1.0 (1.0–1.1)
Job/Financial problem¶¶	**2,941 (16.2)**	1,530 (16.8)	1,411 (15.6)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Eviction or loss of home	**722 (3.8)**	317 (3.4)	405 (4.3)	<0.01	1.3 (1.1–1.5)	1.4 (1.2–1.6)
School problem***	**162 (19.9)**	70 (17.8)	92 (21.9)	NS	1.3 (0.9–1.8)	1.3 (0.9–1.9)
Recent release from an institution†††	**1,412 (7.6)**	941 (10.2)	471 (5.1)	<0.01	0.5 (0.4–0.5)	0.5 (0.4–0.5)
Jail/Prison/Detention facility	**203 (14.4)**	82 (8.7)	121 (25.7)	<0.01	3.6 (2.7–4.9)	4.5 (3.2–6.4)
Hospital	**517 (36.6)**	311 (33.0)	206 (43.7)	<0.01	1.6 (1.3–2.0)	1.3 (1.0–1.7)
Psychiatric hospital/institution	**469 (33.2)**	439 (46.7)	30 (6.4)	<0.01	0.1 (0.1–0.1)	0.1 (0.1–0.1)
Other (includes alcohol/SU treatment facilities)	**223 (15.8)**	109 (11.6)	114 (24.2)	<0.01	2.4 (1.8–3.3)	2.5 (1.8–3.3)

See table footnotes on next page.

Suicidologists regularly state that suicide is not caused by a single factor (*5*); however, suicide prevention is often oriented toward mental health conditions alone with regard to downstream identification of suicidal persons, treatment of mental health conditions, and prevention of reattempts. This study found that approximately half of suicide decedents in NVDRS did not have a known mental health condition, indicating that additional focus on nonmental health factors further upstream could provide important information for a public health approach (*10*). Those without a known mental health condition suffered more from relationship problems and other life stressors such as criminal/legal matters, eviction/loss of home, and recent or impending crises.

Similarly, persons with mental health conditions also often experienced other circumstances such as relationship problems and job/financial or physical health problems that contributed to their suicide. These findings point to the need to both prevent the circumstances associated with the onset of mental health conditions and support persons with known mental health conditions to decrease their risk for poor outcomes (*11*). Two thirds of suicide decedents with mental health conditions had a history of treatment for mental health or substance use disorders,

TABLE 2. (*Continued*) Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Crisis within past or upcoming 2 weeks§§§	**5,525 (29.4)**	2,444 (26.0)	3,081 (32.9)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Intimate partner problem	**1,968 (35.6)**	854 (34.9)	1,114 (36.2)	NS	1.1 (0.9–1.2)	1.1 (0.9–1.2)
Physical health problem	**739 (13.4)**	315 (12.9)	424 (13.8)	NS	1.1 (0.9–1.3)	1.0 (0.8–1.2)
Criminal legal problem	**621 (11.2)**	203 (8.3)	418 (13.6)	<0.01	1.7 (1.5–2.1)	1.6 (1.3–1.9)
Family relationship problem	**430 (7.8)**	212 (8.7)	218 (7.1)	<0.05	0.8 (0.7–1.0)	0.9 (0.7–1.1)
Job problem	**354 (6.4)**	191 (7.8)	163 (5.3)	<0.01	0.7 (0.5–0.8)	0.7 (0.5–0.8)
Suicide event/history						
Left a note	**6,468 (34.5)**	3,182 (33.8)	3,286 (35.1)	NS	1.1 (1.0–1.1)	1.2 (1.1–1.2)
Disclosed suicide intent	**4,405 (23.5)**	2,306 (24.5)	2,099 (22.4)	<0.01	0.9 (0.8–1.0)	0.9 (0.8–0.9)
History of ideation	**5,990 (31.9)**	3,838 (40.8)	2,152 (23.0)	<0.01	0.4 (0.4–0.5)	0.4 (0.4–0.5)
History of attempts	**3,732 (19.9)**	2,770 (29.4)	962 (10.3)	<0.01	0.3 (0.3–0.3)	0.3 (0.3–0.3)

Abbreviations: ADD/ADHD = attention deficit disorder/attention deficit hyperactivity disorder; CI = confidence interval; N/A = not applicable; NS = not significant; OR = odds ratio; PTSD = posttraumatic stress disorder; SU = substance use.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was the reference group.

** Includes decedents with one or more diagnosed current mental health conditions, which are not mutually exclusive. Therefore, sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health conditions.

†† The specific type of mental health condition was calculated only among those with one or more known diagnosed mental health conditions.

§§ Not a diagnosis.

¶¶ Denominator is decedents aged ≥18 years.

*** Denominator is decedents aged 10–18 years.

††† Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.

§§§ Denominator of crisis subgroup is decedents with any crisis within past or upcoming 2 weeks. Crises depicted here represent the most commonly occurring categories.

with approximately half in treatment when they died. This finding suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities, such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. In addition, increased access to behavioral health providers in underserved areas is needed, as is expansion of health care systems that integrate physical and behavioral health, with a priority on suicide prevention and patient safety, especially through care transitions (*12*).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belonging and access to informational, tangible, emotional, and social support; and identifying and better supporting persons at risk (e.g., military veterans, persons with physical/mental health conditions) (*12*). Other strategies include creating protective environments (e.g., reducing access to lethal means among persons at risk for suicide, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for persons with mental health conditions and other life challenges), strengthening access to and delivery of care, supporting family and friends after a suicide, and encouraging the media to follow safe reporting recommendations (*12*). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (*10*).

The findings in this report are subject to at least three limitations. First, in the state-level analysis, rankings for four states (Maryland, Massachusetts, Rhode Island, and Utah) might have been affected by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward) or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml). Finally, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies that include more in-depth interviews with next-of-kin often identify greater attributions to mental health disorders

Summary

What is already known about this topic?

In 2016, nearly 45,000 persons died by suicide in the United States. Mental health conditions are one of several contributors to suicide.

What is added by this report?

During 1999–2016, suicide rates increased in nearly every state, including >30% increases in 25 states. 2015 data from 27 states indicate 54% of suicide decedents were not known to have mental health conditions. Relationship, substance use, health, and job or financial problems are among the other circumstances contributing to suicide.

What are the implications for public health practice?

A comprehensive approach using proven prevention strategies, such as those in CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, can help reach the national goal of reducing the annual suicide rate 20% by 2025.

(*13*); however, many methodological variations across studies exist (*14*). It is likely that some persons without known mental health conditions in the current study were experiencing mental health challenges that were unknown, undiagnosed, or not reported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (*12*) to better understand suicide in their populations, prioritize evidence-based comprehensive suicide prevention, and save lives.

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Conflict of Interest

No conflicts of interest were reported.

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Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30 ¶¶)	+ 34.1 % (23 ¶¶)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3 ¶¶)	+ 46.5 % (4 ¶¶)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Different ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Different ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Different ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

State Abbreviations: AL Alabama; AK Alaska; AZ Arizona; AR Arkansas; CA California; CO Colorado; CT Connecticut; DE Delaware; DC District of Columbia; FL Florida; GA Georgia; HI Hawaii; ID Idaho; IL Illinois; IN Indiana; IA Iowa; KS Kansas; KY Kentucky; LA Louisiana; ME Maine; MD Maryland; MA Massachusetts; MI Michigan; MN Minnesota; MS Mississippi; MO Missouri; MT Montana; NE Nebraska; NV Nevada; NH New Hampshire; NJ New Jersey; NM New Mexico; NY New York; NC North Carolina; ND North Dakota; OH Ohio; OK Oklahoma; OR Oregon; PA Pennsylvania; RI Rhode Island; SC South Carolina; SD South Dakota; TN Tennessee; TX Texas; UT Utah; VT Vermont; VA Virginia; WA Washington; WV West Virginia; WI Wisconsin; WY Wyoming.

#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



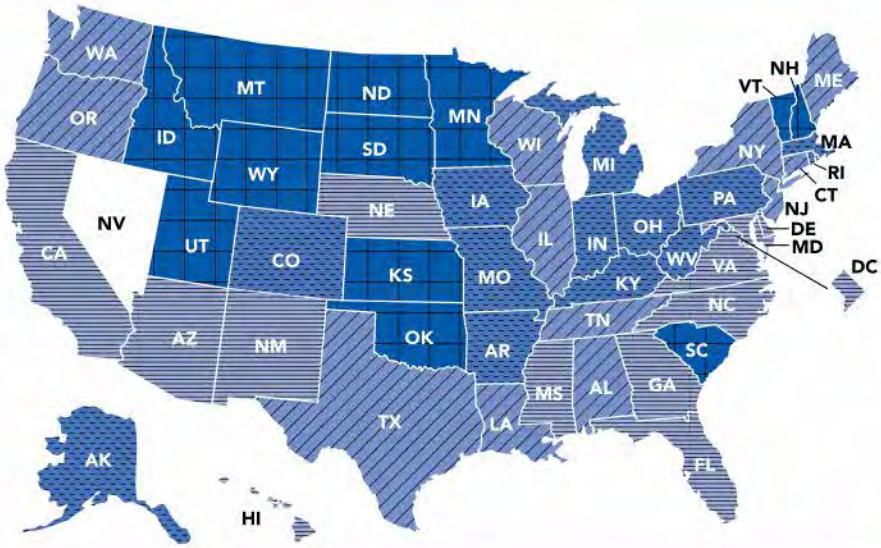
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

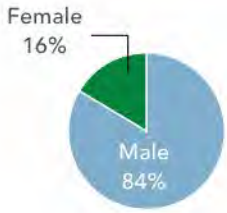


Differences exist among those with and without mental health conditions.

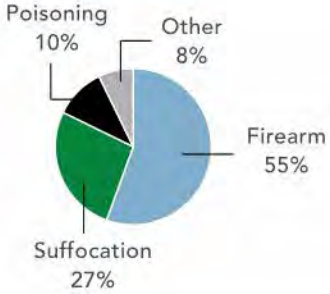
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

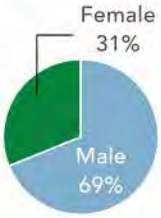


Method

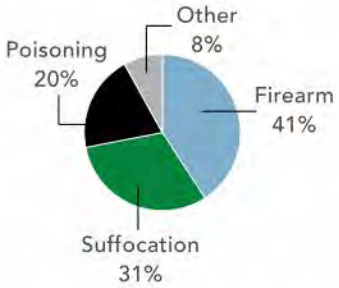


Known mental health conditions

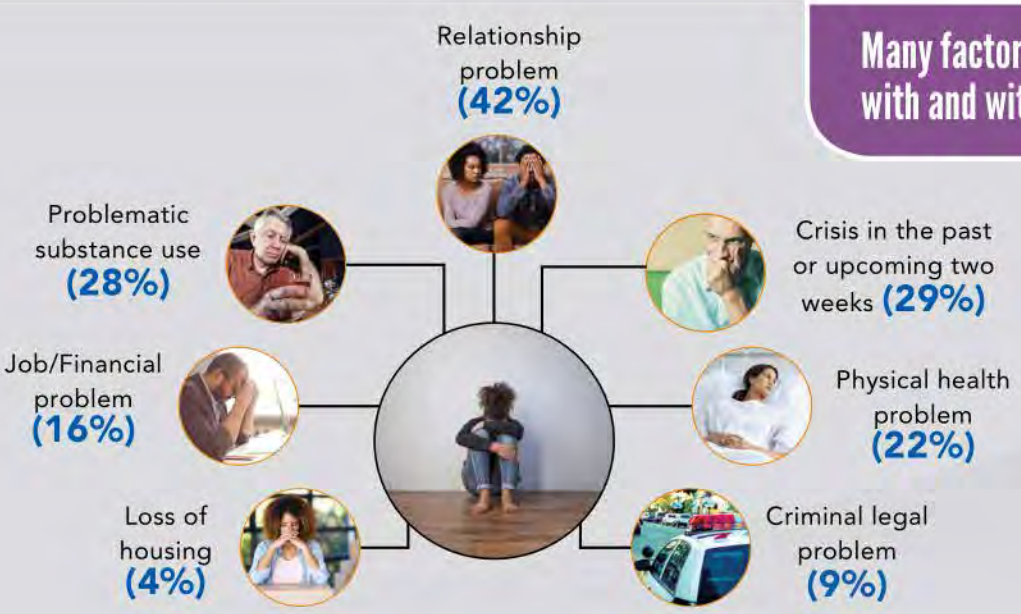
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 09:30:26 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Embargoed until 1pm June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
Attachments: MMWR_Vital Signs_ Suicide_6.7.2018_article.pdf, MMWR Supplemental table__VS Suicide_ 6.7.2018_final.pdf, FACT SHEET_Vital Signs_June_2018_Suicide_Final_WEB.pdf

Here you go. Feel free to add your own note before sending to personalize.
The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.
This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).
Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 67 / No. 22
June 8, 2018

Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

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Abstract

Introduction: Suicide rates in the United States have risen nearly 30% since 1999, and mental health conditions are one of several factors contributing to suicide. Examining state-level trends in suicide and the multiple circumstances contributing to it can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among persons aged ≥10 years, by state and sex, across six consecutive 3-year periods (1999–2016), were assessed using data from the National Vital Statistics System for 50 states and the District of Columbia. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health conditions.

Results: During 1999–2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases >30%. Rates increased significantly among males and females in 34 and 43 states, respectively. Fifty-four percent of decedents in 27 states in 2015 did not have a known mental health condition. Among decedents with available information, several circumstances were significantly more likely among those without known mental health conditions than among those with mental health conditions, including relationship problems/loss (45.1% versus 39.6%), life stressors (50.5% versus 47.2%), and recent/impending crises (32.9% versus 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states during 1999–2016. Various circumstances contributed to suicides among persons with and without known mental health conditions.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends and family members in the aftermath of a suicide.

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U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Introduction

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (*1*). From 1999 to 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (*2,3*). Suicide rates have also increased among persons in all age groups <75 years, with adults aged 45–64 having the largest absolute rate increase (from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (232,108) during the same period (*1,3*). Suicide is the tenth leading cause of death and is one of just three leading causes that are increasing (*1,4*). In addition, rates of emergency department visits for nonfatal self-harm, a main risk factor for suicide, increased 42% from 2001 to 2016 (*1*). Together, suicides and self-harm injuries cost the nation approximately $70 billion per year in direct medical and work loss costs (*1*).

The National Strategy for Suicide Prevention (*5*) calls for a public health approach to suicide prevention with efforts spanning multiple levels (individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is determined by multiple factors. Despite this call to action, suicide prevention largely focuses on identifying and referring suicidal persons to mental health treatment and preventing reattempts (*6*). In addition to mental health conditions and prior suicide attempts, other contributing circumstances include social and economic problems, access to lethal means (e.g., substances, firearms) among persons at risk, and poor coping and problem-solving skills (*5*). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them can help reach the national goal, established by the National Action Alliance of Suicide Prevention and the American Foundation for Suicide Prevention, of reducing the annual suicide rate 20% by 2025 (*7*). To assist states in achieving this goal, CDC analyzed state-specific trends in suicide rates and assessed the multiple contributing factors to suicide; this report presents options for strategies to include in comprehensive suicide prevention efforts that are based on the best available evidence.

Methods

Suicide rates were analyzed for persons aged ≥10 years because determining suicidal intent in younger children can be difficult (*8*). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases, Tenth Revision,* underlying-cause-of death codes X60–X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive 3-year aggregate periods spanning 1999–2016 (1999–2001; 2002–2004; 2005–2007; 2008–2010; 2011–2013; and 2014–2016). Rate estimates were age-adjusted to the U.S. 2000 standard population and expressed

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per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same 3-year data aggregates, employing weighted least-squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes.

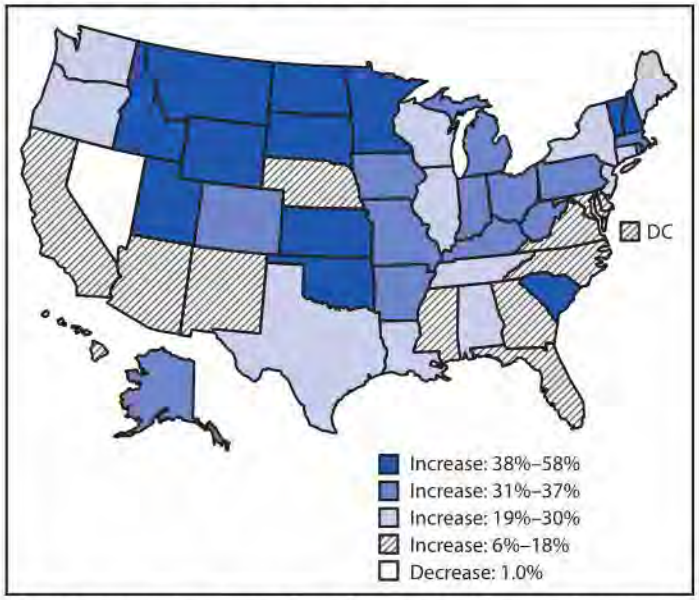
Characteristics of persons aged ≥10 years who died by suicide, with and without known mental health conditions, and the circumstances surrounding the suicides were compared in the 27 states* with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines mental health conditions as disorders and syndromes listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*9*), with the exception of problematic alcohol use and other substance use that are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. A range of circumstances (relationship problems, life stressors, and recent or impending crises) have been identified as potential risk factors for suicide in NVDRS. Circumstances captured are those identified as contributing to suicide in coroner/medical examiner or law enforcement reports, which reflect information provided by family and friends at the time of death. Decedents could have experienced multiple circumstances. Decedents with and without known mental health conditions were compared using chi-square tests. Logistic regression analyses were used to estimate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), controlling for sex, age group, and race/ethnicity.

Results

The most recent overall suicide rates (representing 2014–2016) varied fourfold, from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Across the study period, rates increased in all states except Nevada (where the rate was consistently high throughout the study period), with absolute increases ranging from 0.8 per 100,000 (Delaware) to 8.1 (Wyoming). Percentage increases in rates ranged from 5.9% (Delaware) to 57.6% (North Dakota), with increases >30% observed in 25 states (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785) (Figure).

Modeled suicide rate trends indicated significant increases in 44 states, among males (34 states) and females (43 states), as well as for the United States overall (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Nationally, the model-estimated average annual percentage change for the overall suicide rate was an increase of 1.5%. By sex, estimated national rate trends further indicated significant average annual percentage change increases for males (1.1%) and females (2.6%) (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785).

FIGURE. Percent change in annual suicide rate,* by state — United States, from 1999–2001 to 2014–2016



* Per 100,000 population, age-adjusted to the 2000 U.S. standard population.

Suicide decedents without known mental health conditions (11,039; 54.0%) were compared with those with known mental health conditions (9,407; 46.0%) for 27 states. Whereas decedents were predominantly male (76.8%) (Table 1) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely to be male (83.6% versus 68.8%; odds ratio [OR] = 2.3, 95% CI = 2.2–2.5) and belong to a racial/ethnic minority (OR range = 1.2–2.0). Suicide decedents without known mental health conditions also had significantly higher odds of perpetrating homicide followed by suicide (aOR = 2.9, 95% CI = 2.2–3.8). Among decedents aged ≥18 years, 20.1% of those without known mental health conditions and 15.3% of those with mental health conditions had previously served in the U.S. military or were serving at the time of death.

Whereas firearms were the most common method of suicide overall (48.5%), decedents without known mental health conditions were more likely to die by firearm (55.3%) and less likely to die by hanging/strangulation/suffocation (26.9%) or poisoning (10.4%) than were those with known mental health conditions (40.6%, 31.3%, and 19.8%, respectively). These differences remained significant in the adjusted models.

Toxicology testing was less likely to be performed for decedents without known mental health conditions. Among those with toxicology results, decedents without known mental health

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

TABLE 1. Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	**15,702 (76.8)**	6,469 (68.8)	9,233 (83.6)	<0.01	2.3 (2.2–2.5)	NA
Female	**4,744 (23.2)**	2,938 (31.2)	1,806 (16.4)	<0.01	0.4 (0.4–0.5)	NA
Age group (yrs)**						
10–24	**2,804 (13.7)**	1,211 (12.9)	1,593 (14.4)	<0.01	1.1 (1.1–1.2)	NA
25–44	**6,456 (31.6)**	3,036 (32.3)	3,420 (31.0)	<0.05	0.9 (0.9–1.0)	NA
45–64	**7,718 (37.7)**	3,820 (40.6)	3,898 (35.3)	<0.01	0.8 (0.8–0.8)	NA
≥65	**3,468 (17.0)**	1,340 (14.2)	2,128 (19.3)	<0.01	1.4 (1.3–1.5)	NA
Race/Ethnicity						
White, non-Hispanic	**17,102 (83.6)**	8,165 (86.8)	8,937 (81.0)	<0.01	0.6 (0.6–0.7)	NA
Black, non-Hispanic	**1,228 (6.0)**	411 (4.4)	817 (7.4)	<0.01	1.7 (1.5–2.0)	NA
American Indian/Alaska Native, non-Hispanic	**378 (1.8)**	112 (1.2)	266 (2.4)	<0.01	2.0 (1.6–2.6)	NA
Asian, non-Hispanic	**576 (2.8)**	235 (2.5)	341 (3.1)	<0.05	1.2 (1.1–1.5)	NA
Hispanic	**1,096 (5.4)**	463 (4.9)	633 (5.7)	<0.05	1.2 (1.0–1.3)	NA
Other	**66 (0.3)**	21 (0.2)	45 (0.4)	<0.05	1.8 (1.1–3.1)	NA
Extended demographics						
Ever served in military††	**3,429 (17.8)**	1,354 (15.3)	2,075 (20.1)	<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	**240 (1.2)**	104 (1.1)	136 (1.3)	NS	1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident type						
Single suicide	**20,063 (98.2)**	9,318 (99.1)	10,745 (97.4)	<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	**319 (1.6)**	64 (0.7)	255 (2.3)	<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	**64 (0.3)**	25 (0.3)	39 (0.4)	NS	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	**9,909 (48.5)**	3,821 (40.6)	6,088 (55.3)	<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	**5,907 (28.9)**	2,940 (31.3)	2,967 (26.9)	<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	**3,003 (14.7)**	1,861 (19.8)	1,142 (10.4)	<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	**1,021 (34.0)**	666 (35.8)	355 (31.1)	<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	**944 (31.4)**	608 (32.7)	336 (29.4)	NS	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	**800 (26.6)**	644 (34.6)	156 (13.7)	<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	**624 (20.8)**	468 (25.1)	156 (13.7)	<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	**219 (7.3)**	195 (10.5)	24 (2.1)	<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	**1,595 (7.8)**	780 (8.3)	815 (7.4)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)

See table footnotes on next page.

conditions were less likely to test positive for any substance overall (aOR = 0.8, 95% CI = 0.7–0.8), including opioids (aOR = 0.90, 95% CI = 0.81–0.99), but were more likely to test positive for alcohol (aOR = 1.2, 95%, CI = 1.1–1.3).

Information on circumstances surrounding suicide were available for all decedents with mental health conditions (9,407) and approximately 85% of those without known mental health conditions (9,357) in 27 states (Table 2). Persons without known mental health conditions were less likely to have any problematic substance use (aOR = 0.7, 95% CI = 0.7–0.8) than were persons with known mental health conditions. Whereas two thirds of decedents with known mental health conditions had a history of mental health or substance use treatment (67.2%), just over half (54.0%) were in treatment at the time of death.

Decedents without known mental health conditions had a significantly higher likelihood of any relationship problem/loss (45.1%) than did those with known mental health conditions (39.6%), specifically intimate partner problems (30.2% versus 24.1%), arguments/conflicts (17.5% versus 13.6%), and perpetrating interpersonal violence in the past month (3.0% versus 1.4%). Decedents without known mental health conditions were also more likely than were those with known mental health conditions to have experienced any life stressors (50.5% versus 47.2%) such as recent criminal legal problems (10.7% versus 6.2%) or eviction/loss of home (4.3% versus 3.4%) and were more likely to have had a recent or impending (within the preceding or upcoming 2 weeks, respectively) crisis (a current or acute event thought to contribute to the suicide) (32.9% versus 26.0%). All of these differences remained significant in the adjusted models. Physical health problems and job/financial problems were commonly contributing stressors among both persons without mental health conditions (23.2% and 15.6%, respectively) and those with mental health conditions (21.4%

TABLE 1. (*Continued*) Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Toxicology results						
Any toxicology testing	**13,317 (65.1)**	6,658 (70.8)	6,659 (60.3)	<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	**9,913 (74.4)**	5,192 (78.0)	4,721 (70.9)	<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected* **						
Alcohol						
Tested	**10,950 (53.6)**	5,409 (57.5)	5,541 (50.2)	<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	**4,442 (40.6)**	2,115 (39.1)	2,327 (42.0)	<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	**8,554 (41.8)**	4,258 (45.3)	4,296 (38.9)	<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	**2,279 (26.6)**	1,238 (29.1)	1,041 (24.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	**8,124 (39.7)**	4,226 (44.9)	3,898 (35.3)	<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	**2,464 (30.3)**	1,639 (38.8)	825 (21.2)	<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	**7,978 (39.0)**	3,866 (41.1)	4,112 (37.2)	<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	**499 (6.3)**	216 (5.6)	283 (6.9)	<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	**7,615 (37.2)**	3,696 (39.3)	3,919 (35.5)	<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	**736 (9.7)**	376 (10.2)	360 (9.2)	NS	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	**6,569 (32.1)**	3,127 (33.2)	3,442 (31.2)	<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	**1,471 (22.4)**	710 (22.7)	761 (22.1)	NS	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	**5,425 (26.5)**	3,103 (33.0)	2,322 (21.0)	<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	**2,214 (40.8)**	1,735 (55.9)	479 (20.6)	<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviations: CI = confidence interval; NA = not adjusted; NS = not significant; OR = odds ratio.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology testing.

*** Denominator for each positive group is the number tested for the substance in that group.

and 16.8%, respectively). Similarly, among all persons with recent crises, intimate partner problems were the most common types and did not differ by group.

Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR = 0.5, 95% CI = 0.4–0.5). Among those recently released, decedents without known mental health conditions were significantly more likely than decedents with mental health conditions to have been released from a correctional facility (25.7% versus 8.7%), hospital (43.7% versus 33.0%), or other facility, such as an alcohol/substance use treatment facility (24.2% versus 11.6%). Among decedents with known mental health conditions who were recently released from an institution, 46.7% were released from psychiatric facilities.

Decedents without known mental health conditions were significantly less likely to have a history of suicidal ideation (23.0%) or prior suicide attempts (10.3%) compared with those with known mental health conditions (40.8% and 29.4%, respectively). Suicide intent was disclosed by 22.4% and 24.5% of persons without and with known mental health conditions, respectively.

Conclusions and Comments

During 1999–2016, suicide rates increased significantly in 44 states, and 25 states experienced increases >30%. Rates increased significantly among males in 34 states, and females in 43 states. Additional research into the specific causes of these trends is needed. Data from the 27 states participating in NVDRS provide important insight into circumstances surrounding suicide and can help states identify prevention priorities.

TABLE 2. Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	**18,764 (91.8)**	9,407 (100)	9,357 (84.8)	<0.01	N/A	N/A
Mental health						
Any current diagnosed mental health condition**						
Depression/Dysthymia	—††	7,076 (75.2)	N/A	N/A	N/A	N/A
Anxiety disorder	—††	1,579 (16.8)	N/A	N/A	N/A	N/A
Bipolar disorder	—††	1,431 (15.2)	N/A	N/A	N/A	N/A
Schizophrenia	—††	509 (5.4)	N/A	N/A	N/A	N/A
PTSD	—††	424 (4.5)	N/A	N/A	N/A	N/A
ADD/ADHD	—††	226 (2.4)	N/A	N/A	N/A	N/A
Not specified	—††	760 (8.1)	N/A	N/A	N/A	N/A
Current depressed mood§§	**7,038 (37.5)**	3,962 (42.1)	3,076 (32.9)	<0.01	0.7 (0.6–0.7)	0.7 (0.6–0.7)
Problematic substance use						
Any	**5,319 (28.3)**	2,976 (31.6)	2,343 (25.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Alcohol	**3,268 (17.4)**	1,862 (19.8)	1,406 (15.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Other	**3,084 (16.4)**	1,768 (18.8)	1,316 (14.1)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Treatment						
Current mental health/substance use treatment	**5,141 (27.4)**	5,077 (54.0)	64 (0.7)	<0.01	0.01 (0.01–0.01)	0.01 (0.01–0.01)
Ever treated for mental health/substance disorder	**6,717 (35.8)**	6,323 (67.2)	394 (4.2)	<0.01	0.02 (0.02–0.02)	0.02 (0.02–0.03)
Relationship problems/loss						
Any relationship problem/loss	**7,948 (42.4)**	3,726 (39.6)	4,222 (45.1)	<0.01	1.3 (1.2–1.3)	1.3 (1.2–1.4)
Intimate partner problem	**5,098 (27.2)**	2,270 (24.1)	2,828 (30.2)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Perpetrator of interpersonal violence in past month	**414 (2.2)**	131 (1.4)	283 (3.0)	<0.01	2.2 (1.8–2.7)	2.0 (1.6–2.4)
Victim of interpersonal violence in past month	**84 (0.4)**	53 (0.6)	31 (0.3)	<0.05	0.6 (0.4–0.9)	0.8 (0.5–1.2)
Family relationship problem	**1,671 (8.9)**	873 (9.3)	798 (8.5)	NS	0.9 (0.8–1.0)	1.0 (0.9–1.1)
Other relationship problem (nonintimate)	**403 (2.1)**	202 (2.1)	201 (2.1)	NS	1.0 (0.8–1.2)	1.1 (0.9–1.3)
Argument or conflict (not specified)	**2,914 (15.5)**	1,278 (13.6)	1,636 (17.5)	<0.01	1.3 (1.2–1.5)	1.4 (1.3–1.5)
Death of a loved one (any)	**1,497 (8.0)**	826 (8.8)	671 (7.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–0.9)
Nonsuicide death	**1,181 (6.3)**	647 (6.9)	534 (5.7)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Suicide of family or friend	**379 (2.0)**	217 (2.3)	162 (1.7)	<0.01	0.7 (0.6–0.9)	0.8 (0.7–1.0)
Other life stressors						
Any life stressor	**9,171 (48.9)**	4,442 (47.2)	4,729 (50.5)	<0.01	1.1 (1.1–1.2)	1.1 (1.0–1.2)
Recent criminal legal problem	**1,588 (8.5)**	586 (6.2)	1,002 (10.7)	<0.01	1.8 (1.6–2.0)	1.7 (1.5–1.9)
Other legal problem	**748 (4.0)**	378 (4.0)	370 (4.0)	NS	1.0 (0.8–1.1)	1.0 (0.9–1.2)
Physical health problem	**4,179 (22.3)**	2,012 (21.4)	2,167 (23.2)	<0.01	1.1 (1.0–1.2)	1.0 (1.0–1.1)
Job/Financial problem¶¶	**2,941 (16.2)**	1,530 (16.8)	1,411 (15.6)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Eviction or loss of home	**722 (3.8)**	317 (3.4)	405 (4.3)	<0.01	1.3 (1.1–1.5)	1.4 (1.2–1.6)
School problem***	**162 (19.9)**	70 (17.8)	92 (21.9)	NS	1.3 (0.9–1.8)	1.3 (0.9–1.9)
Recent release from an institution†††	**1,412 (7.6)**	941 (10.2)	471 (5.1)	<0.01	0.5 (0.4–0.5)	0.5 (0.4–0.5)
Jail/Prison/Detention facility	**203 (14.4)**	82 (8.7)	121 (25.7)	<0.01	3.6 (2.7–4.9)	4.5 (3.2–6.4)
Hospital	**517 (36.6)**	311 (33.0)	206 (43.7)	<0.01	1.6 (1.3–2.0)	1.3 (1.0–1.7)
Psychiatric hospital/institution	**469 (33.2)**	439 (46.7)	30 (6.4)	<0.01	0.1 (0.1–0.1)	0.1 (0.1–0.1)
Other (includes alcohol/SU treatment facilities)	**223 (15.8)**	109 (11.6)	114 (24.2)	<0.01	2.4 (1.8–3.3)	2.5 (1.8–3.3)

See table footnotes on next page.

Suicidologists regularly state that suicide is not caused by a single factor (*5*); however, suicide prevention is often oriented toward mental health conditions alone with regard to downstream identification of suicidal persons, treatment of mental health conditions, and prevention of reattempts. This study found that approximately half of suicide decedents in NVDRS did not have a known mental health condition, indicating that additional focus on nonmental health factors further upstream could provide important information for a public health approach (*10*). Those without a known mental health condition suffered more from relationship problems and other life stressors such as criminal/legal matters, eviction/loss of home, and recent or impending crises.

Similarly, persons with mental health conditions also often experienced other circumstances such as relationship problems and job/financial or physical health problems that contributed to their suicide. These findings point to the need to both prevent the circumstances associated with the onset of mental health conditions and support persons with known mental health conditions to decrease their risk for poor outcomes (*11*). Two thirds of suicide decedents with mental health conditions had a history of treatment for mental health or substance use disorders,

TABLE 2. (*Continued*) Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Crisis within past or upcoming 2 weeks§§§	**5,525 (29.4)**	2,444 (26.0)	3,081 (32.9)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Intimate partner problem	**1,968 (35.6)**	854 (34.9)	1,114 (36.2)	NS	1.1 (0.9–1.2)	1.1 (0.9–1.2)
Physical health problem	**739 (13.4)**	315 (12.9)	424 (13.8)	NS	1.1 (0.9–1.3)	1.0 (0.8–1.2)
Criminal legal problem	**621 (11.2)**	203 (8.3)	418 (13.6)	<0.01	1.7 (1.5–2.1)	1.6 (1.3–1.9)
Family relationship problem	**430 (7.8)**	212 (8.7)	218 (7.1)	<0.05	0.8 (0.7–1.0)	0.9 (0.7–1.1)
Job problem	**354 (6.4)**	191 (7.8)	163 (5.3)	<0.01	0.7 (0.5–0.8)	0.7 (0.5–0.8)
Suicide event/history						
Left a note	**6,468 (34.5)**	3,182 (33.8)	3,286 (35.1)	NS	1.1 (1.0–1.1)	1.2 (1.1–1.2)
Disclosed suicide intent	**4,405 (23.5)**	2,306 (24.5)	2,099 (22.4)	<0.01	0.9 (0.8–1.0)	0.9 (0.8–0.9)
History of ideation	**5,990 (31.9)**	3,838 (40.8)	2,152 (23.0)	<0.01	0.4 (0.4–0.5)	0.4 (0.4–0.5)
History of attempts	**3,732 (19.9)**	2,770 (29.4)	962 (10.3)	<0.01	0.3 (0.3–0.3)	0.3 (0.3–0.3)

Abbreviations: ADD/ADHD = attention deficit disorder/attention deficit hyperactivity disorder; CI = confidence interval; N/A = not applicable; NS = not significant; OR = odds ratio; PTSD = posttraumatic stress disorder; SU = substance use.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was the reference group.

** Includes decedents with one or more diagnosed current mental health conditions, which are not mutually exclusive. Therefore, sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health conditions.

†† The specific type of mental health condition was calculated only among those with one or more known diagnosed mental health conditions.

§§ Not a diagnosis.

¶¶ Denominator is decedents aged ≥18 years.

*** Denominator is decedents aged 10–18 years.

††† Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.

§§§ Denominator of crisis subgroup is decedents with any crisis within past or upcoming 2 weeks. Crises depicted here represent the most commonly occurring categories.

with approximately half in treatment when they died. This finding suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities, such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. In addition, increased access to behavioral health providers in underserved areas is needed, as is expansion of health care systems that integrate physical and behavioral health, with a priority on suicide prevention and patient safety, especially through care transitions (*12*).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belonging and access to informational, tangible, emotional, and social support; and identifying and better supporting persons at risk (e.g., military veterans, persons with physical/mental health conditions) (*12*). Other strategies include creating protective environments (e.g., reducing access to lethal means among persons at risk for suicide, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for persons with mental health conditions and other life challenges), strengthening access to and delivery of care, supporting family and friends after a suicide, and encouraging the media to follow safe reporting recommendations (*12*). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (*10*).

The findings in this report are subject to at least three limitations. First, in the state-level analysis, rankings for four states (Maryland, Massachusetts, Rhode Island, and Utah) might have been affected by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward) or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml). Finally, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies that include more in-depth interviews with next-of-kin often identify greater attributions to mental health disorders

Summary

What is already known about this topic?

In 2016, nearly 45,000 persons died by suicide in the United States. Mental health conditions are one of several contributors to suicide.

What is added by this report?

During 1999–2016, suicide rates increased in nearly every state, including >30% increases in 25 states. 2015 data from 27 states indicate 54% of suicide decedents were not known to have mental health conditions. Relationship, substance use, health, and job or financial problems are among the other circumstances contributing to suicide.

What are the implications for public health practice?

A comprehensive approach using proven prevention strategies, such as those in CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, can help reach the national goal of reducing the annual suicide rate 20% by 2025.

(*13*); however, many methodological variations across studies exist (*14*). It is likely that some persons without known mental health conditions in the current study were experiencing mental health challenges that were unknown, undiagnosed, or not reported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (*12*) to better understand suicide in their populations, prioritize evidence-based comprehensive suicide prevention, and save lives.

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Conflict of Interest

No conflicts of interest were reported.

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Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30 ¶¶)	+ 34.1 % (23 ¶¶)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3 ¶¶)	+ 46.5 % (4 ¶¶)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Different ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Different ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Different ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

State Abbreviations: AL Alabama; AK Alaska; AZ Arizona; AR Arkansas; CA California; CO Colorado; CT Connecticut; DE Delaware; DC District of Columbia; FL Florida; GA Georgia; HI Hawaii; ID Idaho; IL Illinois; IN Indiana; IA Iowa; KS Kansas; KY Kentucky; LA Louisiana; ME Maine; MD Maryland; MA Massachusetts; MI Michigan; MN Minnesota; MS Mississippi; MO Missouri; MT Montana; NE Nebraska; NV Nevada; NH New Hampshire; NJ New Jersey; NM New Mexico; NY New York; NC North Carolina; ND North Dakota; OH Ohio; OK Oklahoma; OR Oregon; PA Pennsylvania; RI Rhode Island; SC South Carolina; SD South Dakota; TN Tennessee; TX Texas; UT Utah; VT Vermont; VA Virginia; WA Washington; WV West Virginia; WI Wisconsin; WY Wyoming.

#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



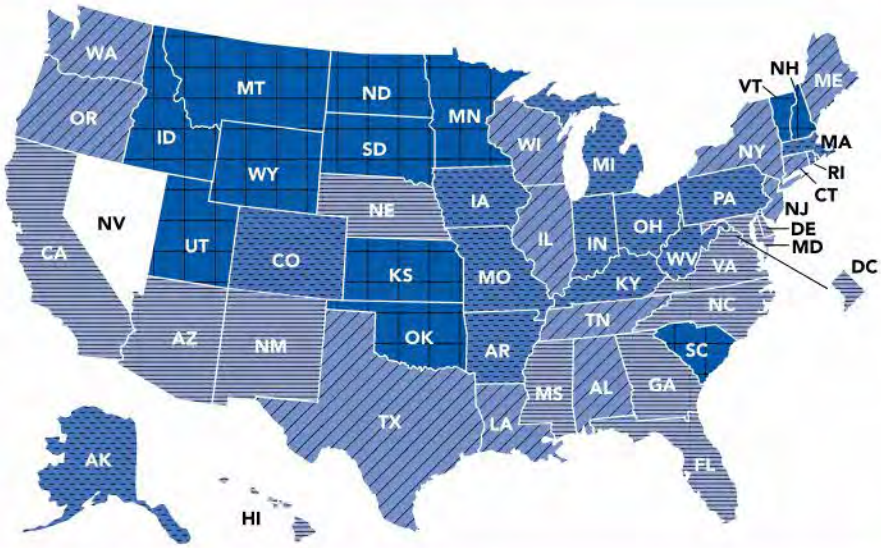
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

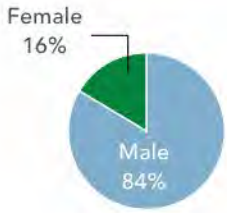


Differences exist among those with and without mental health conditions.

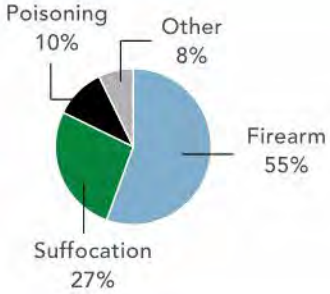
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

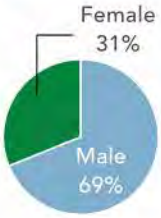


Method

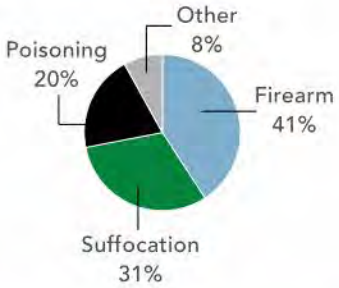


Known mental health conditions

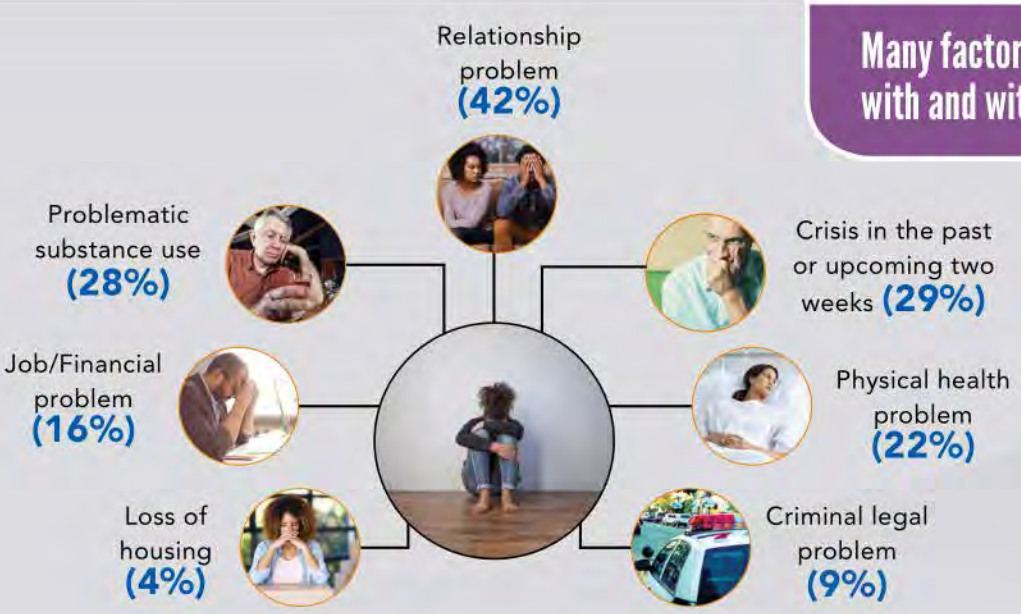
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 6 Jun 2018 16:36:29 -0400
To: Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Cc: Blair, Janet (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Subject: EMBARGOED UNTIL 1PM June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
Attachments: MMWR Supplemental table__VS Suicide_ 6.7.2018_final.pdf, MMWR_Vital Signs_ Suicide_6.7.2018_article.pdf, FACT SHEET_Vital Signs_June_2018_Suicide_Final_WEB.pdf, NVDRS TPs.docx

Shane – Here is the email (below) and attachments to share with NVDRS PIs tomorrow morning at 9am (please do not send out before 9am). As requested by the NVDRS principle investigators, I've also attached internal talking points that they may use if they choose.
Malia
++
Dear NVDRS Principle Investigators:
The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.
This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpageto find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).
Social Media Handles and Twitter Chat:

Please save the date for our upcoming Twitter chat:

The Twitter chat, scheduled for June 11th from 2-3PM ET, will be co-hosted by CDC (@CDCInjury) and The National Action Alliance for Suicide Prevention (@Action_Alliance).

Day: Monday, June 11th

Time: 2:00-3:00PM ET

Place: Twitter.com from your computer or mobile device and search the hashtag #SuicideChat

During the chat, you'll be able to:

- Gain key insights into the most recent @CDCInjury Vital Signs issue
- Ask questions of experts from @CDCInjury and @Action_Alliance
- Share your own prevention resources and stories

Spread the Word

- Tweet: Join the @CDCinjury & @ActionAlliance #SuicideChat on Monday June 11 2-3PM ET. Topics covered include the latest @CDCgov #VitalSigns issue and rates of #suicide in the US.

Additionally, watch for social posts from these handles:

- CDC Facebook
- CDC Twitter
- CDC eHealth Twitter
- CDC Injury Twitter
- CDC VetoViolence Facebook
- CDC LinkedIn
- CDC Google+
- CDC Pinterest
- CDC Instagram (check the stories after 1pm ET)
- CDC Director Twitter

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30 ¶¶)	+ 34.1 % (23 ¶¶)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3 ¶¶)	+ 46.5 % (4 ¶¶)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Different ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Different ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Different ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

State Abbreviations: AL Alabama; AK Alaska; AZ Arizona; AR Arkansas; CA California; CO Colorado; CT Connecticut; DE Delaware; DC District of Columbia; FL Florida; GA Georgia; HI Hawaii; ID Idaho; IL Illinois; IN Indiana; IA Iowa; KS Kansas; KY Kentucky; LA Louisiana; ME Maine; MD Maryland; MA Massachusetts; MI Michigan; MN Minnesota; MS Mississippi; MO Missouri; MT Montana; NE Nebraska; NV Nevada; NH New Hampshire; NJ New Jersey; NM New Mexico; NY New York; NC North Carolina; ND North Dakota; OH Ohio; OK Oklahoma; OR Oregon; PA Pennsylvania; RI Rhode Island; SC South Carolina; SD South Dakota; TN Tennessee; TX Texas; UT Utah; VT Vermont; VA Virginia; WA Washington; WV West Virginia; WI Wisconsin; WY Wyoming.

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Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

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Abstract

Introduction: Suicide rates in the United States have risen nearly 30% since 1999, and mental health conditions are one of several factors contributing to suicide. Examining state-level trends in suicide and the multiple circumstances contributing to it can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among persons aged ≥10 years, by state and sex, across six consecutive 3-year periods (1999–2016), were assessed using data from the National Vital Statistics System for 50 states and the District of Columbia. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health conditions.

Results: During 1999–2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases >30%. Rates increased significantly among males and females in 34 and 43 states, respectively. Fifty-four percent of decedents in 27 states in 2015 did not have a known mental health condition. Among decedents with available information, several circumstances were significantly more likely among those without known mental health conditions than among those with mental health conditions, including relationship problems/loss (45.1% versus 39.6%), life stressors (50.5% versus 47.2%), and recent/impending crises (32.9% versus 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states during 1999–2016. Various circumstances contributed to suicides among persons with and without known mental health conditions.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends and family members in the aftermath of a suicide.

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Introduction

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (*1*). From 1999 to 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (*2,3*). Suicide rates have also increased among persons in all age groups <75 years, with adults aged 45–64 having the largest absolute rate increase (from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (232,108) during the same period (*1,3*). Suicide is the tenth leading cause of death and is one of just three leading causes that are increasing (*1,4*). In addition, rates of emergency department visits for nonfatal self-harm, a main risk factor for suicide, increased 42% from 2001 to 2016 (*1*). Together, suicides and self-harm injuries cost the nation approximately $70 billion per year in direct medical and work loss costs (*1*).

The National Strategy for Suicide Prevention (*5*) calls for a public health approach to suicide prevention with efforts spanning multiple levels (individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is determined by multiple factors. Despite this call to action, suicide prevention largely focuses on identifying and referring suicidal persons to mental health treatment and preventing reattempts (*6*). In addition to mental health conditions and prior suicide attempts, other contributing circumstances include social and economic problems, access to lethal means (e.g., substances, firearms) among persons at risk, and poor coping and problem-solving skills (*5*). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them can help reach the national goal, established by the National Action Alliance of Suicide Prevention and the American Foundation for Suicide Prevention, of reducing the annual suicide rate 20% by 2025 (*7*). To assist states in achieving this goal, CDC analyzed state-specific trends in suicide rates and assessed the multiple contributing factors to suicide; this report presents options for strategies to include in comprehensive suicide prevention efforts that are based on the best available evidence.

Methods

Suicide rates were analyzed for persons aged ≥10 years because determining suicidal intent in younger children can be difficult (*8*). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases, Tenth Revision,* underlying-cause-of death codes X60–X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive 3-year aggregate periods spanning 1999–2016 (1999–2001; 2002–2004; 2005–2007; 2008–2010; 2011–2013; and 2014–2016). Rate estimates were age-adjusted to the U.S. 2000 standard population and expressed

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per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same 3-year data aggregates, employing weighted least-squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes.

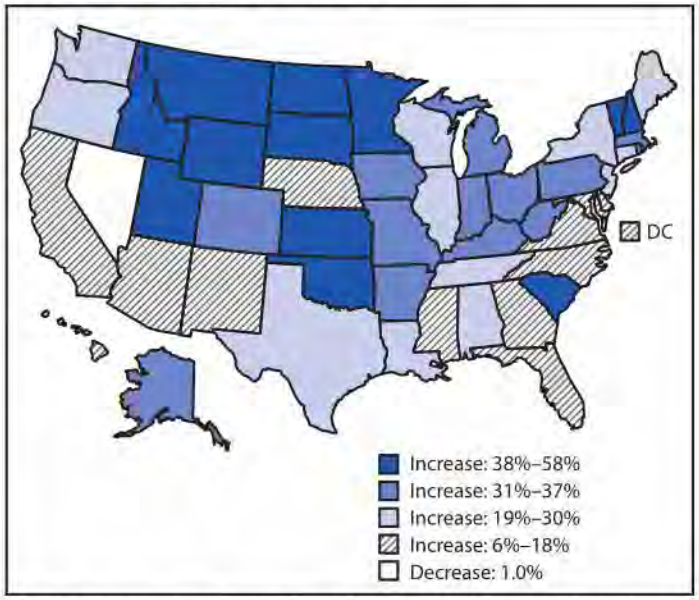
Characteristics of persons aged ≥10 years who died by suicide, with and without known mental health conditions, and the circumstances surrounding the suicides were compared in the 27 states* with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines mental health conditions as disorders and syndromes listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*9*), with the exception of problematic alcohol use and other substance use that are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. A range of circumstances (relationship problems, life stressors, and recent or impending crises) have been identified as potential risk factors for suicide in NVDRS. Circumstances captured are those identified as contributing to suicide in coroner/medical examiner or law enforcement reports, which reflect information provided by family and friends at the time of death. Decedents could have experienced multiple circumstances. Decedents with and without known mental health conditions were compared using chi-square tests. Logistic regression analyses were used to estimate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), controlling for sex, age group, and race/ethnicity.

Results

The most recent overall suicide rates (representing 2014–2016) varied fourfold, from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Across the study period, rates increased in all states except Nevada (where the rate was consistently high throughout the study period), with absolute increases ranging from 0.8 per 100,000 (Delaware) to 8.1 (Wyoming). Percentage increases in rates ranged from 5.9% (Delaware) to 57.6% (North Dakota), with increases >30% observed in 25 states (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785) (Figure).

Modeled suicide rate trends indicated significant increases in 44 states, among males (34 states) and females (43 states), as well as for the United States overall (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Nationally, the model-estimated average annual percentage change for the overall suicide rate was an increase of 1.5%. By sex, estimated national rate trends further indicated significant average annual percentage change increases for males (1.1%) and females (2.6%) (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785).

FIGURE. Percent change in annual suicide rate,* by state — United States, from 1999–2001 to 2014–2016



* Per 100,000 population, age-adjusted to the 2000 U.S. standard population.

Suicide decedents without known mental health conditions (11,039; 54.0%) were compared with those with known mental health conditions (9,407; 46.0%) for 27 states. Whereas decedents were predominantly male (76.8%) (Table 1) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely to be male (83.6% versus 68.8%; odds ratio [OR] = 2.3, 95% CI = 2.2–2.5) and belong to a racial/ethnic minority (OR range = 1.2–2.0). Suicide decedents without known mental health conditions also had significantly higher odds of perpetrating homicide followed by suicide (aOR = 2.9, 95% CI = 2.2–3.8). Among decedents aged ≥18 years, 20.1% of those without known mental health conditions and 15.3% of those with mental health conditions had previously served in the U.S. military or were serving at the time of death.

Whereas firearms were the most common method of suicide overall (48.5%), decedents without known mental health conditions were more likely to die by firearm (55.3%) and less likely to die by hanging/strangulation/suffocation (26.9%) or poisoning (10.4%) than were those with known mental health conditions (40.6%, 31.3%, and 19.8%, respectively). These differences remained significant in the adjusted models.

Toxicology testing was less likely to be performed for decedents without known mental health conditions. Among those with toxicology results, decedents without known mental health

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

TABLE 1. Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	**15,702 (76.8)**	6,469 (68.8)	9,233 (83.6)	<0.01	2.3 (2.2–2.5)	NA
Female	**4,744 (23.2)**	2,938 (31.2)	1,806 (16.4)	<0.01	0.4 (0.4–0.5)	NA
Age group (yrs)**						
10–24	**2,804 (13.7)**	1,211 (12.9)	1,593 (14.4)	<0.01	1.1 (1.1–1.2)	NA
25–44	**6,456 (31.6)**	3,036 (32.3)	3,420 (31.0)	<0.05	0.9 (0.9–1.0)	NA
45–64	**7,718 (37.7)**	3,820 (40.6)	3,898 (35.3)	<0.01	0.8 (0.8–0.8)	NA
≥65	**3,468 (17.0)**	1,340 (14.2)	2,128 (19.3)	<0.01	1.4 (1.3–1.5)	NA
Race/Ethnicity						
White, non-Hispanic	**17,102 (83.6)**	8,165 (86.8)	8,937 (81.0)	<0.01	0.6 (0.6–0.7)	NA
Black, non-Hispanic	**1,228 (6.0)**	411 (4.4)	817 (7.4)	<0.01	1.7 (1.5–2.0)	NA
American Indian/Alaska Native, non-Hispanic	**378 (1.8)**	112 (1.2)	266 (2.4)	<0.01	2.0 (1.6–2.6)	NA
Asian, non-Hispanic	**576 (2.8)**	235 (2.5)	341 (3.1)	<0.05	1.2 (1.1–1.5)	NA
Hispanic	**1,096 (5.4)**	463 (4.9)	633 (5.7)	<0.05	1.2 (1.0–1.3)	NA
Other	**66 (0.3)**	21 (0.2)	45 (0.4)	<0.05	1.8 (1.1–3.1)	NA
Extended demographics						
Ever served in military††	**3,429 (17.8)**	1,354 (15.3)	2,075 (20.1)	<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	**240 (1.2)**	104 (1.1)	136 (1.3)	NS	1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident type						
Single suicide	**20,063 (98.2)**	9,318 (99.1)	10,745 (97.4)	<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	**319 (1.6)**	64 (0.7)	255 (2.3)	<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	**64 (0.3)**	25 (0.3)	39 (0.4)	NS	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	**9,909 (48.5)**	3,821 (40.6)	6,088 (55.3)	<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	**5,907 (28.9)**	2,940 (31.3)	2,967 (26.9)	<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	**3,003 (14.7)**	1,861 (19.8)	1,142 (10.4)	<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	**1,021 (34.0)**	666 (35.8)	355 (31.1)	<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	**944 (31.4)**	608 (32.7)	336 (29.4)	NS	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	**800 (26.6)**	644 (34.6)	156 (13.7)	<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	**624 (20.8)**	468 (25.1)	156 (13.7)	<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	**219 (7.3)**	195 (10.5)	24 (2.1)	<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	**1,595 (7.8)**	780 (8.3)	815 (7.4)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)

See table footnotes on next page.

conditions were less likely to test positive for any substance overall (aOR = 0.8, 95% CI = 0.7–0.8), including opioids (aOR = 0.90, 95% CI = 0.81–0.99), but were more likely to test positive for alcohol (aOR = 1.2, 95%, CI = 1.1–1.3).

Information on circumstances surrounding suicide were available for all decedents with mental health conditions (9,407) and approximately 85% of those without known mental health conditions (9,357) in 27 states (Table 2). Persons without known mental health conditions were less likely to have any problematic substance use (aOR = 0.7, 95% CI = 0.7–0.8) than were persons with known mental health conditions. Whereas two thirds of decedents with known mental health conditions had a history of mental health or substance use treatment (67.2%), just over half (54.0%) were in treatment at the time of death.

Decedents without known mental health conditions had a significantly higher likelihood of any relationship problem/loss (45.1%) than did those with known mental health conditions (39.6%), specifically intimate partner problems (30.2% versus 24.1%), arguments/conflicts (17.5% versus 13.6%), and perpetrating interpersonal violence in the past month (3.0% versus 1.4%). Decedents without known mental health conditions were also more likely than were those with known mental health conditions to have experienced any life stressors (50.5% versus 47.2%) such as recent criminal legal problems (10.7% versus 6.2%) or eviction/loss of home (4.3% versus 3.4%) and were more likely to have had a recent or impending (within the preceding or upcoming 2 weeks, respectively) crisis (a current or acute event thought to contribute to the suicide) (32.9% versus 26.0%). All of these differences remained significant in the adjusted models. Physical health problems and job/financial problems were commonly contributing stressors among both persons without mental health conditions (23.2% and 15.6%, respectively) and those with mental health conditions (21.4%

TABLE 1. (*Continued*) Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Toxicology results						
Any toxicology testing	**13,317 (65.1)**	6,658 (70.8)	6,659 (60.3)	<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	**9,913 (74.4)**	5,192 (78.0)	4,721 (70.9)	<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected* **						
Alcohol						
Tested	**10,950 (53.6)**	5,409 (57.5)	5,541 (50.2)	<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	**4,442 (40.6)**	2,115 (39.1)	2,327 (42.0)	<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	**8,554 (41.8)**	4,258 (45.3)	4,296 (38.9)	<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	**2,279 (26.6)**	1,238 (29.1)	1,041 (24.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	**8,124 (39.7)**	4,226 (44.9)	3,898 (35.3)	<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	**2,464 (30.3)**	1,639 (38.8)	825 (21.2)	<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	**7,978 (39.0)**	3,866 (41.1)	4,112 (37.2)	<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	**499 (6.3)**	216 (5.6)	283 (6.9)	<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	**7,615 (37.2)**	3,696 (39.3)	3,919 (35.5)	<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	**736 (9.7)**	376 (10.2)	360 (9.2)	NS	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	**6,569 (32.1)**	3,127 (33.2)	3,442 (31.2)	<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	**1,471 (22.4)**	710 (22.7)	761 (22.1)	NS	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	**5,425 (26.5)**	3,103 (33.0)	2,322 (21.0)	<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	**2,214 (40.8)**	1,735 (55.9)	479 (20.6)	<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviations: CI = confidence interval; NA = not adjusted; NS = not significant; OR = odds ratio.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology testing.

*** Denominator for each positive group is the number tested for the substance in that group.

and 16.8%, respectively). Similarly, among all persons with recent crises, intimate partner problems were the most common types and did not differ by group.

Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR = 0.5, 95% CI = 0.4–0.5). Among those recently released, decedents without known mental health conditions were significantly more likely than decedents with mental health conditions to have been released from a correctional facility (25.7% versus 8.7%), hospital (43.7% versus 33.0%), or other facility, such as an alcohol/substance use treatment facility (24.2% versus 11.6%). Among decedents with known mental health conditions who were recently released from an institution, 46.7% were released from psychiatric facilities.

Decedents without known mental health conditions were significantly less likely to have a history of suicidal ideation (23.0%) or prior suicide attempts (10.3%) compared with those with known mental health conditions (40.8% and 29.4%, respectively). Suicide intent was disclosed by 22.4% and 24.5% of persons without and with known mental health conditions, respectively.

Conclusions and Comments

During 1999–2016, suicide rates increased significantly in 44 states, and 25 states experienced increases >30%. Rates increased significantly among males in 34 states, and females in 43 states. Additional research into the specific causes of these trends is needed. Data from the 27 states participating in NVDRS provide important insight into circumstances surrounding suicide and can help states identify prevention priorities.

TABLE 2. Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	**18,764 (91.8)**	9,407 (100)	9,357 (84.8)	<0.01	N/A	N/A
Mental health						
Any current diagnosed mental health condition**						
Depression/Dysthymia	—††	7,076 (75.2)	N/A	N/A	N/A	N/A
Anxiety disorder	—††	1,579 (16.8)	N/A	N/A	N/A	N/A
Bipolar disorder	—††	1,431 (15.2)	N/A	N/A	N/A	N/A
Schizophrenia	—††	509 (5.4)	N/A	N/A	N/A	N/A
PTSD	—††	424 (4.5)	N/A	N/A	N/A	N/A
ADD/ADHD	—††	226 (2.4)	N/A	N/A	N/A	N/A
Not specified	—††	760 (8.1)	N/A	N/A	N/A	N/A
Current depressed mood§§	**7,038 (37.5)**	3,962 (42.1)	3,076 (32.9)	<0.01	0.7 (0.6–0.7)	0.7 (0.6–0.7)
Problematic substance use						
Any	**5,319 (28.3)**	2,976 (31.6)	2,343 (25.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Alcohol	**3,268 (17.4)**	1,862 (19.8)	1,406 (15.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Other	**3,084 (16.4)**	1,768 (18.8)	1,316 (14.1)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Treatment						
Current mental health/substance use treatment	**5,141 (27.4)**	5,077 (54.0)	64 (0.7)	<0.01	0.01 (0.01–0.01)	0.01 (0.01–0.01)
Ever treated for mental health/substance disorder	**6,717 (35.8)**	6,323 (67.2)	394 (4.2)	<0.01	0.02 (0.02–0.02)	0.02 (0.02–0.03)
Relationship problems/loss						
Any relationship problem/loss	**7,948 (42.4)**	3,726 (39.6)	4,222 (45.1)	<0.01	1.3 (1.2–1.3)	1.3 (1.2–1.4)
Intimate partner problem	**5,098 (27.2)**	2,270 (24.1)	2,828 (30.2)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Perpetrator of interpersonal violence in past month	**414 (2.2)**	131 (1.4)	283 (3.0)	<0.01	2.2 (1.8–2.7)	2.0 (1.6–2.4)
Victim of interpersonal violence in past month	**84 (0.4)**	53 (0.6)	31 (0.3)	<0.05	0.6 (0.4–0.9)	0.8 (0.5–1.2)
Family relationship problem	**1,671 (8.9)**	873 (9.3)	798 (8.5)	NS	0.9 (0.8–1.0)	1.0 (0.9–1.1)
Other relationship problem (nonintimate)	**403 (2.1)**	202 (2.1)	201 (2.1)	NS	1.0 (0.8–1.2)	1.1 (0.9–1.3)
Argument or conflict (not specified)	**2,914 (15.5)**	1,278 (13.6)	1,636 (17.5)	<0.01	1.3 (1.2–1.5)	1.4 (1.3–1.5)
Death of a loved one (any)	**1,497 (8.0)**	826 (8.8)	671 (7.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–0.9)
Nonsuicide death	**1,181 (6.3)**	647 (6.9)	534 (5.7)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Suicide of family or friend	**379 (2.0)**	217 (2.3)	162 (1.7)	<0.01	0.7 (0.6–0.9)	0.8 (0.7–1.0)
Other life stressors						
Any life stressor	**9,171 (48.9)**	4,442 (47.2)	4,729 (50.5)	<0.01	1.1 (1.1–1.2)	1.1 (1.0–1.2)
Recent criminal legal problem	**1,588 (8.5)**	586 (6.2)	1,002 (10.7)	<0.01	1.8 (1.6–2.0)	1.7 (1.5–1.9)
Other legal problem	**748 (4.0)**	378 (4.0)	370 (4.0)	NS	1.0 (0.8–1.1)	1.0 (0.9–1.2)
Physical health problem	**4,179 (22.3)**	2,012 (21.4)	2,167 (23.2)	<0.01	1.1 (1.0–1.2)	1.0 (1.0–1.1)
Job/Financial problem¶¶	**2,941 (16.2)**	1,530 (16.8)	1,411 (15.6)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Eviction or loss of home	**722 (3.8)**	317 (3.4)	405 (4.3)	<0.01	1.3 (1.1–1.5)	1.4 (1.2–1.6)
School problem***	**162 (19.9)**	70 (17.8)	92 (21.9)	NS	1.3 (0.9–1.8)	1.3 (0.9–1.9)
Recent release from an institution†††	**1,412 (7.6)**	941 (10.2)	471 (5.1)	<0.01	0.5 (0.4–0.5)	0.5 (0.4–0.5)
Jail/Prison/Detention facility	**203 (14.4)**	82 (8.7)	121 (25.7)	<0.01	3.6 (2.7–4.9)	4.5 (3.2–6.4)
Hospital	**517 (36.6)**	311 (33.0)	206 (43.7)	<0.01	1.6 (1.3–2.0)	1.3 (1.0–1.7)
Psychiatric hospital/institution	**469 (33.2)**	439 (46.7)	30 (6.4)	<0.01	0.1 (0.1–0.1)	0.1 (0.1–0.1)
Other (includes alcohol/SU treatment facilities)	**223 (15.8)**	109 (11.6)	114 (24.2)	<0.01	2.4 (1.8–3.3)	2.5 (1.8–3.3)

See table footnotes on next page.

Suicidologists regularly state that suicide is not caused by a single factor (*5*); however, suicide prevention is often oriented toward mental health conditions alone with regard to downstream identification of suicidal persons, treatment of mental health conditions, and prevention of reattempts. This study found that approximately half of suicide decedents in NVDRS did not have a known mental health condition, indicating that additional focus on nonmental health factors further upstream could provide important information for a public health approach (*10*). Those without a known mental health condition suffered more from relationship problems and other life stressors such as criminal/legal matters, eviction/loss of home, and recent or impending crises.

Similarly, persons with mental health conditions also often experienced other circumstances such as relationship problems and job/financial or physical health problems that contributed to their suicide. These findings point to the need to both prevent the circumstances associated with the onset of mental health conditions and support persons with known mental health conditions to decrease their risk for poor outcomes (*11*). Two thirds of suicide decedents with mental health conditions had a history of treatment for mental health or substance use disorders,

TABLE 2. (*Continued*) Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Crisis within past or upcoming 2 weeks§§§	**5,525 (29.4)**	2,444 (26.0)	3,081 (32.9)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Intimate partner problem	**1,968 (35.6)**	854 (34.9)	1,114 (36.2)	NS	1.1 (0.9–1.2)	1.1 (0.9–1.2)
Physical health problem	**739 (13.4)**	315 (12.9)	424 (13.8)	NS	1.1 (0.9–1.3)	1.0 (0.8–1.2)
Criminal legal problem	**621 (11.2)**	203 (8.3)	418 (13.6)	<0.01	1.7 (1.5–2.1)	1.6 (1.3–1.9)
Family relationship problem	**430 (7.8)**	212 (8.7)	218 (7.1)	<0.05	0.8 (0.7–1.0)	0.9 (0.7–1.1)
Job problem	**354 (6.4)**	191 (7.8)	163 (5.3)	<0.01	0.7 (0.5–0.8)	0.7 (0.5–0.8)
Suicide event/history						
Left a note	**6,468 (34.5)**	3,182 (33.8)	3,286 (35.1)	NS	1.1 (1.0–1.1)	1.2 (1.1–1.2)
Disclosed suicide intent	**4,405 (23.5)**	2,306 (24.5)	2,099 (22.4)	<0.01	0.9 (0.8–1.0)	0.9 (0.8–0.9)
History of ideation	**5,990 (31.9)**	3,838 (40.8)	2,152 (23.0)	<0.01	0.4 (0.4–0.5)	0.4 (0.4–0.5)
History of attempts	**3,732 (19.9)**	2,770 (29.4)	962 (10.3)	<0.01	0.3 (0.3–0.3)	0.3 (0.3–0.3)

Abbreviations: ADD/ADHD = attention deficit disorder/attention deficit hyperactivity disorder; CI = confidence interval; N/A = not applicable; NS = not significant; OR = odds ratio; PTSD = posttraumatic stress disorder; SU = substance use.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was the reference group.

** Includes decedents with one or more diagnosed current mental health conditions, which are not mutually exclusive. Therefore, sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health conditions.

†† The specific type of mental health condition was calculated only among those with one or more known diagnosed mental health conditions.

§§ Not a diagnosis.

¶¶ Denominator is decedents aged ≥18 years.

*** Denominator is decedents aged 10–18 years.

††† Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.

§§§ Denominator of crisis subgroup is decedents with any crisis within past or upcoming 2 weeks. Crises depicted here represent the most commonly occurring categories.

with approximately half in treatment when they died. This finding suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities, such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. In addition, increased access to behavioral health providers in underserved areas is needed, as is expansion of health care systems that integrate physical and behavioral health, with a priority on suicide prevention and patient safety, especially through care transitions (*12*).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belonging and access to informational, tangible, emotional, and social support; and identifying and better supporting persons at risk (e.g., military veterans, persons with physical/mental health conditions) (*12*). Other strategies include creating protective environments (e.g., reducing access to lethal means among persons at risk for suicide, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for persons with mental health conditions and other life challenges), strengthening access to and delivery of care, supporting family and friends after a suicide, and encouraging the media to follow safe reporting recommendations (*12*). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (*10*).

The findings in this report are subject to at least three limitations. First, in the state-level analysis, rankings for four states (Maryland, Massachusetts, Rhode Island, and Utah) might have been affected by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward) or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml). Finally, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies that include more in-depth interviews with next-of-kin often identify greater attributions to mental health disorders

Summary

What is already known about this topic?

In 2016, nearly 45,000 persons died by suicide in the United States. Mental health conditions are one of several contributors to suicide.

What is added by this report?

During 1999–2016, suicide rates increased in nearly every state, including >30% increases in 25 states. 2015 data from 27 states indicate 54% of suicide decedents were not known to have mental health conditions. Relationship, substance use, health, and job or financial problems are among the other circumstances contributing to suicide.

What are the implications for public health practice?

A comprehensive approach using proven prevention strategies, such as those in CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, can help reach the national goal of reducing the annual suicide rate 20% by 2025.

(*13*); however, many methodological variations across studies exist (*14*). It is likely that some persons without known mental health conditions in the current study were experiencing mental health challenges that were unknown, undiagnosed, or not reported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (*12*) to better understand suicide in their populations, prioritize evidence-based comprehensive suicide prevention, and save lives.

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Conflict of Interest

No conflicts of interest were reported.

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#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



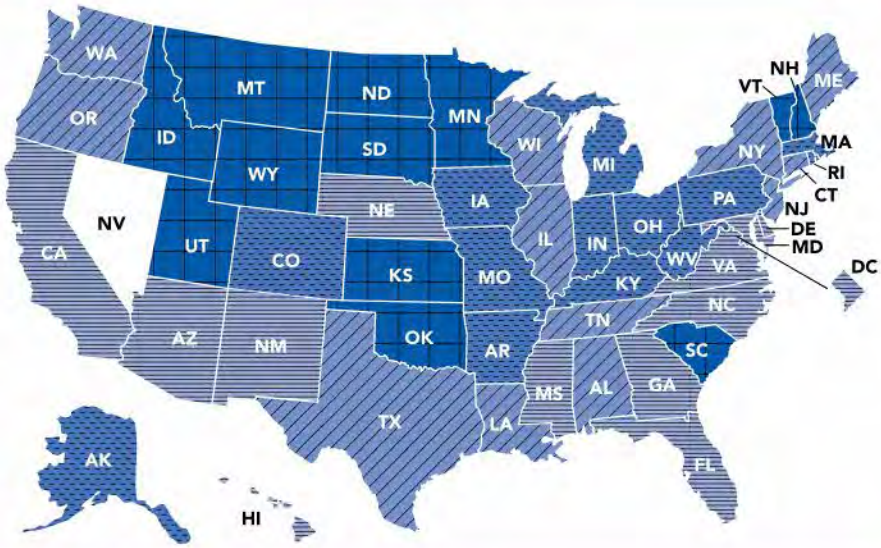
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

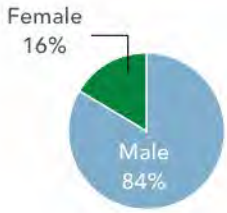


Differences exist among those with and without mental health conditions.

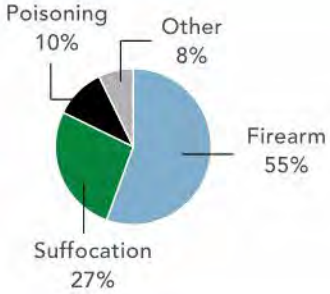
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

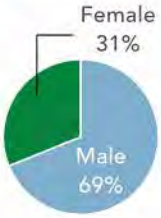


Method

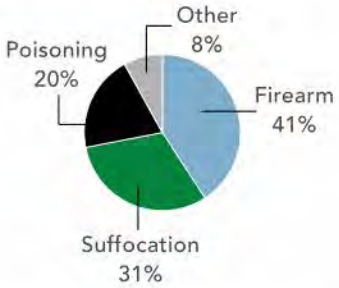


Known mental health conditions

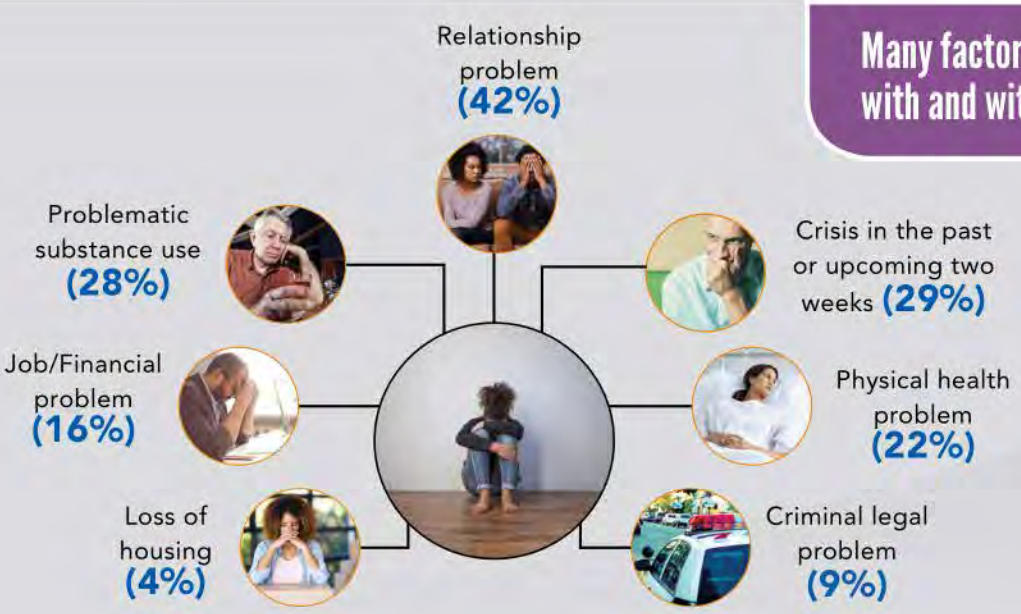
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018

TALKING POINTS and FAQs for NVDRS Principle Investigators Only
DO NOT DISTRIBUTE

Overall key messages:

- Nearly 45,000 lives were lost to suicide in 2016 alone, about one suicide every 12 minutes.
- Between 1999 and 2016, suicide rates increased among all age groups younger than 75 years.
- Suicide rates have also been rising in nearly every state.
- There are a range of factors and circumstances that contribute to suicide risk.
    - EMBARGOED: CDC found that **more than half of people** who died by suicide did not have a known diagnosed mental health condition at the time of death.
    - **Factors that contribute** to suicide risk: Relationship problems or loss, substance misuse; physical health problems; and job, money, legal or housing stress.

The problem:

- Suicide is the **10th leading cause of death** and is one of just three leading causes that are on the rise.
- Suicide is more than a mental health condition.
    - EMBARGOED: CDC's findings show that **fewer than half of the people** who lost their life to suicide had a known mental health condition – and in many of cases, other factors were involved.
- There are **many opportunities for prevention** in addition to treating those with mental health conditions:
    - teaching coping and problem-solving skills to help people manage life challenges;
    - promoting safe and supportive environments, including safe storage of medications and firearms among people at risk;
    - providing temporary help for people struggling to make ends meet, and encouraging connectedness so people are less likely to feel alone or isolated.
- Using a **comprehensive approach** can help the nation reach its goal of reducing the annual suicide rate 20 percent by 2025.

Study details:

- CDC analyzed data from the National Vital Statistics System to look at trends in suicide rates for all 50 states and DC.
    - Between 1999 and 2016, trends in suicide rates were assessed among people ages 10 and above, and by state and sex.

- CDC then looked at data from CDC's National Violent Death Reporting System – which covered 27 states in 2015 – to examine circumstances around suicides among people with and without known mental health conditions.
- EMBARGOED: **CDC found that suicide rates increased in almost all states**.
    - The increases ranged from almost 6 percent in Delaware to nearly 58 percent in North Dakota, with **increases of more than 30 percent in 25 states**.
- EMBARGOED: CDC also found that **54% of people who died by suicide did *not* have a known mental condition**.
    - This group suffered from relationship problems and other life stresses such as criminal legal matters, eviction/loss of home, and recent or impending crises.
    - However, these factors were common to all people who died by suicide, whether or not they had a diagnosed mental health condition.
- Firearms were the most common method of suicide used by those with and without a known diagnosed mental health condition.

Actions:

- Federal government:
    - CDC is tracking the problem to understand trends and identify the groups at greatest risk.
    - CDC released a technical package on suicide prevention that describes strategies and approaches based on the best available evidence. This can help inform states and communities as they make decisions about prevention activities and priorities.
        - Some of the strategies are designed to prevent suicide risk before it emerges (teaching problem-solving skills, encouraging connectedness, etc.), while others are aimed at supporting those who are already struggling through effective treatment and crisis intervention.
        - The package also describes approaches to prevent future suicide risk among those who have made an attempt, or lost someone to suicide.
- States and communities are: [Suggest customizing to work your state is doing to prevent suicide]
    - Identifying and supporting people at risk of suicide.
    - Promoting safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
    - Connecting people at risk to effective and coordinated mental and physical healthcare. Expand options for temporary assistance for those struggling to make ends meet.
- Healthcare systems can:
    - Provide high-quality, ongoing care focused on patient safety and suicide prevention.

- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

- Employers can:
  - Promote employee health and well-being; support employees at risk; and have plans in place to respond to people showing warning signs.
  - Provide referrals to mental health, substance use, legal or financial counseling services as needed.
- Everyone can:
  - Ask someone you're worried about if they're thinking about suicide.
  - Keep them safe by reducing access to lethal means for those at risk.
  - Be there and listen.
  - Encourage them to seek help, or help them connect with ongoing support, such as the National Suicide Prevention Lifeline (800-273-TALK or 8255)
  - Follow up with them by phone or in person to see how they are doing.
  - Visit BeThe1To.com to learn the warning signs of suicide.

NVDRS

- CDC's National Violent Death Surveillance System (NVDRS) collects the most comprehensive data on the circumstances surrounding violent deaths in the United States. Currently it exists in 40 states, Puerto Rico, and the District of Columbia.

- NVDRS links death certificates, coroner/medical examiner reports and law enforcement reports for both single victim and multiple victim incidents to obtain the most comprehensive data available in a single surveillance system.
  - All manner of violent deaths - including suicide and homicide – are captured.

- NVDRS data help state suicide prevention efforts by providing information on circumstances (e.g., mental health problems; recent problems with a job, finances, school, relationships); demographics; method of death (e.g., hanging/suffocation, firearms, poisoning); victim-suspect relationship; toxicology; and location.

General FAQs

- **How does using the National Violent Death Reporting System help to make suicide statistics more complete?**

  Although limited to the 27 states participating in NVDRS during the time period of the study, **data from NVDRS provide the only detailed information available on the circumstances surrounding these**

deaths, therefore taking the findings beyond reporting numbers and rates and providing unique information on the context in which people die from suicide.

- **Why did CDC only look at suicide circumstances in 27 states?**
    - In 2015, the National Violent Death Reporting System collected data from 27 states. The data collected from these states were used for the analysis. More current data is not yet available.
    - In 2016, NVDRS collected data from 40 states, D.C. and Puerto Rico however data are not yet available.

- **What are the leading ways that people die by suicide?**
    - Firearms are the mechanism for about half of all suicides in the United States.
    - The next leading methods are suffocation and poisoning.

  Reducing access to lethal means of suicide among people at risk for suicide is a proven intervention. This includes:
    - Intervening at suicide hotspots such as bridges
    - Counseling on how to safely store medications, firearms, or other household products.

  These interventions can be combined with other strategies for a comprehensive approach to prevention.

- **What is known about which groups are experiencing increases?**

  The current study found that rates of suicide are increasing, overall, and for males and females. Rates among females increased significantly in 43 states and rates among males increased significantly in 34 states.
    - In general, suicide rates in the U.S. have increased by nearly 30% since 1999.
        i. Increases were observed for both women and men in all age groups under 75.
    - Certain groups have had particularly high greatest increases since 1999, including:
        i. Working-age adults 35-64 yrs
        ii. Non-Hispanic whites, and non-Hispanic American Indians / Alaska Natives and
        iii. People living in rural areas.
        iv. Rates have increased for males and female however the rate for males is consistently 3-5 times higher than the rate for females

- **For some states, the reported percentage increase in the suicide rate is quite large. Is this due simply to fluctuations in small numbers of suicides?**

  The percentages represent increases in rates between the first three-year reporting period (1999-2001) and the last three-year reporting period (2014-2016). By aggregating the data into three-year periods, small suicide counts were avoided.

- **How did CDC define a mental health condition?**

  The National Violent Death Reporting System (NVDRS) defines a mental health condition as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (9), with the exception of alcohol and other substance use problems, which are captured separately in the system.
    a. Data on mental health conditions are abstracted from the investigative reports included within NVDRS and that are associated with each suicide.

b. Investigative reports are those filed by law enforcement and coroners/medical examiners which reflect information provided by family and friends.
c. Information obtained from these reports is dependent upon the extent of informant knowledge that may impact data completeness and accuracy. Some decedents might have mental health conditions that were not diagnosed or reported. The high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

- **Are the people without mental health conditions just people who haven't been diagnosed with a mental health conditions?**
  It is possible that the people without mental health conditions in this study had a diagnosable mental health condition but had not been diagnosed, or that their mental health conditions was unknown to informants who provided circumstantial information to law enforcement. Studies including more in-depth interviews with next-of-kin often cite greater attributions to mental disorders, however many methodological variations across studies exist. It is likely that some people without known mental health conditions in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

- **A lot of the problems mentioned as contributing to suicide in this study seem very common, how can someone tell who's at risk?**
  Many people think that suicide unexplainable, when, in reality, many known risk factors exist.
  These include:
    - History of previous suicide attempts
    - Family history of suicide
    - History of child maltreatment
    - History of depression or other mental illness
    - Alcohol or drug abuse
    - Feelings of hopelessness or isolation
    - Impulsive or aggressive tendencies
    - Stressful life event or loss
    - Easy access to lethal methods
    - Exposure to the suicidal behavior of others
    - Isolation, lack of social connectedness

  Researchers agree that suicidal behavior results from an interaction of factors and is rarely due to a single cause.

- **What can be done to prevent suicide?**

  Suicide is preventable.

  CDC released a technical package of policies, programs, and practices to prevent suicide to help communities focus on a core set of strategies that have the best available evidence and greatest prevention potential.

  The technical package includes examples of programs that local implementers might tailor to fit the needs of their community. The technical package **includes 7 strategies designed to work together to achieve the greatest impact possible**.

i. Strengthen economic supports
ii. Strengthen access and delivery of suicide care
iii. Create protective environments
iv. Promote connectedness
v. Teach coping and problem-solving skills
vi. Identify and support people at risk
vii. Lessen harms and prevent future risk

Preventing Suicide: A Technical Package of Policy, Programs, and Practices:
https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 22 Mar 2018 23:48:26 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC)
Subject: Feedback on Pre-clearance Draft of Suicide Vital Signs MMWR
Attachments: Suicide Vital Signs MMWR Text 3.19.18 v3 (pre-clearance)_CF_EB MRC.docx, MMWR Table 1 and Figure 1_CF.docx, Copy of Copy of Tables (23) Suicide Vital Signs NVDRS_031918 (pre-clearance)_CF.xlsx

Hi Everyone,
I wanted to thank everyone again for the hard work on our pre-clearance draft.
We received feedback from Jim, Erin, Malia, and Cory. See emails below and attached documents.
The feedback was largely very positive but there are comments to address, of course.
The goal is to make revisions and get the next draft into clearance on Tuesday, 3/27.
To make that happen, my plan is to revise the attached draft and send out a new draft to all of you by COB (Friday).
I was then hoping to go through final edits with you on Monday, 3/26 (invite to follow) at 10 am.
I know this may mean you have to review the revised version early on Monday or maybe over the weekend.* Gulp.
If you have a conflict with Monday, then please send me your comments on Monday as soon as you can, but no later than 3:00 so that I can consider them prior to submitting final into clearance.
Thank you for your patience with this quick turnaround. We're definitely going to take time to celebrate at some point soon but not too soon as to jinx ourselves! ;)
Deb
*If you prefer to get started commenting right away, then feel free to review the attached draft and provide your comments to me in an email or via tracked changes on Friday.
Sorry if this seems overly complex, I just want to give you options given the short turnaround.

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 4:47 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR
Thanks for the opportunity to review and for all your hard work on this MMWR. It's really exciting to see the final draft! I think this is going to be very important info for states.
I had some minor comments for your consideration that I added to Erin and Cory's feedback (attached).
No feedback on the tables and figures. Thought the map of the US that showed the percent change in states was nicely done and easy to understand.
Malia

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 3:25 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR

FABULOUS job Deb! This was very exciting and compelling to read! Congratulations on this huge milestone!
I agree with Jim's comment about emphasizing more the increase in female vs. male rates. I also provided some mostly editorial questions/comments and suggested edits in track changes summarized below:

- Sometimes it is referred to as a 'contributing circumstance' and sometimes its referred to as a 'contributing factor'. I wonder if its best to be consistent so as not to confuse the reader that the two are different. From a plain language perspective, I prefer contributing factors? Also, sometimes it is referred to a just 'contributing factor' while other times it is referred to as 'contributing risk factor'. Also, sometime it is referred to as 'contributing' and sometimes as 'associated'. Should we be consistent?
- "Suicide is the 10th leading cause of death and is among the only leading causes to be *increasing*." Can we be more specific – is it the only or is it only one of 2 (e.g.) leading causes increasing – 'among the only' is vague?
- Is it better to say the current 'social ecology' (which I think many think of social, environmental and economic) versus I think what is used most often the 'social ecological model' (individual, family/relationship, community, and societal).
- "can help reach the nation's goal of reducing suicide rates 20% by 2025" – is it really the 'nation's goal' – versus the goal set by the American Foundation for Suicide Prevention.
- "Across the entire study period, rates increased in all but one state (Nevada)." Per our discussion in our last VS group meeting, should we add a note that despite NV not increasing, they still have a significantly high rate of suicide?
- Sometimes criminal-legal is hyphenated and sometimes it's not.
- "Nearly half of suicide decedents in NVDRS had a known MHP." I would add the actual percentage in parenthesis (X%).
- People with known MHP also experienced other life stressors such as job and/or financial, relationship, and/or physical health problems. Should this be 'and', 'or' or 'and/or'?
- "It is likely that some people without known MHP in the current study were experiencing mental health challenges at the time of death that were either not known or reported by informants." Do you mean 'NOT' reported by informants?

From: Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 2:25 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR

Deb,
Congratulations to you and the entire vital signs writing team to getting to this point! It is an enormous achievement. I really like the direction the analyses have gone in. I know there is a considerable amount of work ahead, but you have a solid platform to build on.
I offer in the attachments some suggestions. Track changes are not easily done in the excel file so I highlight words in red to draw your attention to things to consider. In the text, I think there are a few numbers to double check, a few data points and clarifications to be added in, and the references to the tables/figure adjusted. I do like the balance that is currently in there on the %'s versus aORs.
Mental health problems as a driver of suicide jumped out to me as one of the main messages since the text kept coming back to it. I think there are some subtle reorganization or broader phrasing that could

be used in some places to modify this if the communication goal is different; I offer some ideas in comment boxes. I recognize that I am suggesting adding some clarifying text in some places and word count is always an issue, so I did try to identify some places to potentially cut. Please review this as suggestions and take/leave what feels right.
FYI, in a meeting I was in with the MMWR editors yesterday they said they prefer little to no use of acronyms. So, in a few places I suggest taking a couple out but I did leave in the MHP one since that is necessary for word count.
Cory

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 12:34 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR

Hi Deb,
This is outstanding. Thank you and everyone else for this really nice and clear statement about suicide and its prevention. I have just a few general comments/suggestions:

1. One finding that you don't make much of, but I think is important, is that suicide rates across states are increasing faster for females relative to males. Overall, of course, this is a problem still dominated by males, but that appears to be changing. And that's not surprising in terms of societal changes around gender roles and norms. I realize you can't highlight everything, but that is very interesting and may signal a longer term trend that's worth noting.
2. You may have to cut back the word number some and if you do I think you can get away without the second sentence in the results that focusses on absolute changes in rates. People understand the meaning of % changes much easier, so no biggie, but that could be dropped if needed.
3. In regards to the first sentence in the last paragraph, I wondering if the last clause could be changed to "..., but is only one of several..." If we say one of "many" then the argument is that we can't focus on everything so we should focus on the most important risk factor. I'm not wedded to this, but clearly we are emphasizing the need to focus on factors beyond mental illness (but not excluding mental illness) and I think this sentence could be made a little stronger in support of that, especially because it ties things up at the end.

Thanks that is all I had. Thanks so much and can't wait until this comes out.
Jim

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 8:14 AM
To: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: Pre-clearance Draft of Suicide Vital Signs MMWR
Importance: High

Hi Jim, Cory, Erin, and Malia,
Just a friendly reminder to please send your feedback on the MMWR by COB today. Your time and insights are greatly appreciated!
Deb
*****

Hi Everyone,
Please find attached a draft of our suicide Vital Signs MMWR for pre-clearance.
Thank you for previously agreeing to review it with a quick turnaround of COB 3/22.
We are still working out one outstanding issue—whether to report percentages and/or aORs pertaining to NVDRS results.
Right now we opt for percentages however we may also include aOR and CI's.
Please send your edits in tracked changes. If you have any questions, please let me know.
We look forward to your feedback! And thanks to the whole team for a whole lot of time, thought, and expertise dedicated to this draft!
Thanks again!
Deb

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Rev 3.19.18 v3

Short title: Vital Signs: Increasing Trends in State Suicide Rates and Contributing Circumstances

Deborah M. Stone, ScD;[1] Thomas R. Simon PhD;[1] Katherine A. Fowler, PhD;[1] Scott R. Kegler, PhD;[2] Keming Yuan, MS;[1] Kristin M. Holland, PhD;[1] Asha Z. Ivey-Stephenson, PhD;[1] Alex E. Crosby, MD[1]

Structured abstract (256252/250 words—this word count is not included in the 1800 max for the remainder)

Background: Overall sSuicide rates have been rising in the United States since 1999. Examining state-level trends in suicide and its multiple contributing circumstances, can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates, by state and sex, among people aged ≥10 years, were assessed using data from the National Vital Statistics System. Changes in rates were examined across six consecutive three-year periods from 1999-2016. TheCDC's National Violent Death Reporting System (2015), covering 27 states, was used to examine the precipitating circumstances among suicide decedents with and without known mental health problems (MHP).

Results: Forty-four states saw statistically significant sSuicide rates increases increased significantly from 1999-2016 in 44 states. In 25 states, rates increased by 30% or more. Male suicide rates increased significantly in 34 states. while fFemale rates increased significantly in 43 states. People with (46%) and without (54%) known MHP had both differing and similar circumstances precipitating suicide. Several circumstance, such as any relationship problems/loss (39.6 and 45.1%, $p \leq .01$), any life stressors/loss (49.7 and 54.2%, $p \leq .01$), and recent crises (26.0 and 32.9%, $p \leq .01$), respectively, were more likely among those without known MHP, but were common across groups.

Conclusions: Suicide rates rose significantly across most states from 1999-2016. Varied circumstances beyond MHP alone contributed to suicides among people with and without known MHP.

Implications for Public Health Practice: States can use a comprehensive public health approach based on the best available evidence to prevent suicide risks before they occur, identify and support people already at risk, prevent reattempts, and help friends/family after a suicide occurs.

INTRODUCTION

BACKGROUND AND PURPOSE (255/260 words)

In 2016, nearly 45,000 suicides (15.6/100,000) occurred in the United States (U.S.), among people ≥10 years old [1]. Between 1999 and 2016, suicide rates increased across sexes, racial/ethnic groups, and urbanization levels [2, 3]. Suicide is the 10th leading cause of death and is among the only leading causes to be *increasing* [1, 4]. Additionally, rates of Emergency Department visits for nonfatal self-harm injury, a key risk factor for suicide, increased more than 40% between 2001 and 2015 [1]. Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs [1].

The *National Strategy for Suicide Prevention(NSSP)* [5] calls for a public health approach to suicide with prevention with efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal), of the social ecology. Such an approach underscores that suicide is rarely caused by any single factor alone, but rather, is multi-determined. Despite the NSSP guidance, suicide prevention efforts largely focus on identifying and treating individuals with mental health problems (MHP) [6]. Other associated contributing risk factors include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, poor coping and problem-solving skills, and prior suicide attempts, among others [5]. Expanded

Comment [BE(]: Sometimes it is referred to as a 'contributing circumstance' and sometimes its referred to as a 'contributing factor'. I wonder if its

Comment [FC(]: Can a couple of words be added here to reflect a date since rates have been rising. I see word count is an issue and I think a couple of words can

Comment [FC(]: Style consideration. Since focus on suicide and states is clear, may not these words twice in sentence which would reduce word count. A few

Comment [FC(]: The transition from reading NVDRS covers 27 states to methods to the first line in the results referring to 44 states made me pause and

Comment [FC(]: Unclear if this was supposed to be a reference or can come out.

Comment [JRV8]: Just a suggestion and may not be feasible, but would suggest not using MHP through the document. Mental health problems doesn't seem

Comment [BE(]: I think this is a Significant finding should we say more about it the fact that it is increasing more in women?

Comment [FC(]: I think edits are needed here for a few reasons. I am finding the statements that there are differences and similarities vague and hard to follow

Comment [FC(]: Please double check. I am getting 15.9 from WISQARS

Comment [BE(]: Can we be more specific – is it the only or is it one of only X leading causes increasing – 'among the only' is vague?

Comment [FC(]: Please double check. Wonder if this might have been calculated for all ages and not limited to ≥10 years.

Comment [JRV8]: Suggest identifying this as a US Surgeon General report.

Comment [BE(]: Is it better to say social ecology (which I think many think of social, environmental and economic) versus I think what is used most often the

awareness of the additional circumstances that contribute to suicide risk apart from MHP, can help reach the nation's goal of reducing suicide rates 20% by 2025 [7]. To assist states in achieving this goal, this study analyzes state-specific trends in suicide rates, assesses the multiple contributing factors ~~associated with suicide~~, and provides recommendations for multi-level comprehensive suicide prevention.

METHODS (257/260 words)

Suicide rates were analyzed for those aged 10 years and older (because of variability in attributions of suicidal intent, younger children are excluded) [8]. Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases 10th Revision* [ICD-10] underlying-cause-of death codes X60-X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive three-year aggregate periods from 1999-2016. Rate estimates were age-adjusted to the U.S. year 2000 standard population and expressed per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same three-year data aggregates, employing weighted least squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes (AAPCs).

Data from 2015 from the 27 states with complete data participating in ~~the~~CDC's National Violent Death Reporting System (NVDRS), ages 10 and older, were used to compare the characteristics among suicide decedents with and without known current ~~mental health problems~~ (MHP). MHP are defined in NVDRS as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [9], except alcohol and other substance use disorders (captured separately). NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. Decedents with and without known MHP were compared using Chi-square tests; logistic regression was used to estimate adjusted odds ratios with 95% confidence intervals (CI), controlling for age group, sex, and race/ethnicity.

RESULTS (612/591 words)

The most recent overall suicide rates (representing 2014-2016) ranged from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year, a four-fold difference (Table 1). Across the entire study period, rates increased in all but one state (Nevada), with absolute increases ranging from +0.2 (Delaware) to +8.1 (Wyoming) per 100,000. Percentage increases in rates ranged from +5.9% (Delaware) to +57.6% (North Dakota), with percentage increases of at least 30% observed in 25 states.

Modeled suicide rate trends indicated significant increases for 44 states, as well as for the U.S. overall (Table 1). By sex, modeled rate trends indicated significant increases in 34 states for males and in 43 states for females. Nationally, the model-estimated AAPC for the overall suicide rate was +1.5%. By sex, the national AAPC was +1.1% for males and +2.6% for females.

Suicide decedents with (N=9,407) and without (N=11,039) known MHP were compared. ~~While b~~Both groups were predominately male and non-Hispanic white. ~~, s~~Suicide decedents without known MHP relative to those with known MHP were more likely to be male (83.6% vs. 68.8%; p≤.01), and racial/ethnic minorities (odds ratio [OR] range: 1.2-2.1; 95% CI range [1.0-1.3] – [1.6-2.0]). ~~They~~Suicide decedents without known MHP also had significantly greater odds of perpetrating homicide-suicide (adjusted odds ratio [aOR] = 2.9, 95% CI = 2.2-3.8), of firearm suicide (aOR = 1.6, 95% CI = 1.5-1.7), and of positive toxicology results for alcohol (aOR = 1.2, 95% CI = 1.1-1.3). Fifteen percent of ~~those~~adult decedents with known MHP, and 20% without, ~~ever~~ had served or were serving ~~served~~ in the U.S. military.

Comment [BE(]: Is it really the 'nation's goal' – versus the goal set by the American Foundation for Suicide Prevention.

Comment [JRV8]: Sentence has a lot of different points. It may be easier to read if it were two sentences. Suggestion:

Data from the National Violent Death Reporting System (NVDRS) were used to compare characteristics among suicide decedents with and without known current mental health programs. Complete data from 27 states participating in NVDRS in 2015 were used for this analyses.

Comment [FC(]: I am confused by how the alcohol and substance use disorder exception is described. DSM-5 does have an alcohol use disorder diagnosis and a substance use disorder dx.

Comment [FC(]: Some labeling of the tables and how reflected in the text need some modification. There are current two "Table 1" in attachments (i.e., state trends; select demographics). The two NVDRS tables and figure 1 don't appear to

Comment [BE(]: Per our discussion in our last VS group meeting, should we add a note that despite NV not increases, they still have a significantly high rate of suicide?

Comment [FC(]: Please double check. Table reflects +0.8

Comment [FC(]: Suggest revising in order to allow in the next sentence the comparison group to be clear and the order the %'s should be considered clearer. Tracked is an idea.

Comment [FC(]: Wonder if need to be clear here this is limited to 18+. Tracked might be a simple approach to consider.

I have seen MMWR want to present %'s to first decimal place consistently. Here is

Comment [JRV8]: I realize this adds words so you may not be able to do this but the "ever" in the original sentence was confusing/stumbling block to me as a I read. Not sure if the additional language is correct – vets and active duty or just

Although firearms were used most often in both groups, decedents with known MHP died by poisoning more than those without known MHP (19.8% vs. 10.4%; $p \leq .01$), most frequently by over-the-counter/otherwise unclassified drugs (35.8%), opioids (32.7%), antidepressants (34.6%) or benzodiazepines (25.1%).

All suicide decedents with known MHP (N=9,407) and approximately 85% without (N=9,357) had precipitating circumstances ~~information~~ (Table 2 or 3??). People with known MHP were more likely to have any substance abuse problems (31.6% vs. 25%, $p \leq .01$). While two-thirds of those with known MHP had a history of MH or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment at the time of their deaths.

Decedents without known MHP, versus those with known MHP had a greater likelihood of any relationship problem/loss (45.1% ~~and~~vs. 39.6%, $p \leq .01$), specifically intimate partner problems (30.2% ~~and~~vs. 24.1%, $p \leq .01$), arguments/conflicts (17.5% ~~and~~vs. 13.6%, $p \leq .01$), and recently perpetrating interpersonal violence (3.0% ~~and~~vs. 1.4%, $p \leq .01$). They were also more likely to have experienced other life stressors, such as criminal-legal problems (10.7% ~~and~~vs. 6.2%, $p \leq .01$) or eviction/loss of home (4.3% ~~and~~vs. 3.4%, $p \leq .01$), and they were more likely to have had a crisis within the preceding or upcoming two weeks (32.9% ~~and~~vs. 26.0%, $p<.01$). Among both groups, the most common crises were intimate partner (35.6%) and physical health (13.4%) problems.

Decedents without known MHP had significantly lower odds of recent release from any institution, but among those who were recently released, those without a known MHP were more likely to be released from a correctional facility (25.7% vs. 8.7%, $p \leq .01$) or hospital (43.7% vs. 33.0%, $p \leq .01$) than those with a known MHP. Among decedents with known MHP recently released from an institution (10.2%), 42.8% were released from psychiatric facilities.

Suicide decedents without known MHP were more likely than those without known MHP to leave a suicide note (35.1% ~~and~~vs. 31.8%, $p \leq .01$). ~~while d~~Decedents with known MHP, compared to those without known MHP, were more likely to have a history of suicidal ideation (40.8% vs. 23.0%, $p \leq .01$) and attempts (29.4% vs. 10.3%, $p \leq .01$).

Conclusions and Comments (655/715 words)

From 1999-2016, 44 states saw significant suicide rate increases. Half of the states experienced increases of 30% or more. Rates increased significantly in 34 states among males and 43 states among females. More research into the causes of these trends is necessary [10].

One important factor associated with suicide is MHP. Nearly half of suicide decedents in NVDRS had a known MHP. This group was challenged by comorbid substance abuse problems (31.6%) and histories of suicidal ideation (40.8%) and attempts (29.4%). While two-thirds of people with known MHP had a history of MH and/or substance abuse treatment and over half were in treatment at the time of their deaths, additional support ~~could~~ may help address the needs of this vulnerable population. This includes broader implementation of affordable and evidence-based treatments, such as doctor-patient collaborative care models and cognitive-behavioral therapy. Additionally, greater access to behavioral health providers, especially in underserved areas is important, as is healthcare systems ~~change~~ that supports suicide prevention and patient safety through care transitions [11].

While mental health problems are a significant contributor to suicide, 54% of suicide decedents in this study did *not* have a known MHP. This group suffered more relationship problems and life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises. This is noteworthy in light of findings that suggest many suicides and attempts occur with minimal deliberation time, particularly among people without mental health disorders and who faced impending life crises [12].

Comment [FC(]: I think the comparison group %'s are needed. For instance, drugs (35.8% vs. 35.8%).

I think the presentation of the %'s would be easier here and later on in the results if the p's came out and the text could simply reflect "significant differences" or some variation of indicating in the groups were different.

Comment [BE(]: Sometimes criminal-legal is hyphenated and sometimes it's not.

Comment [FC(]: The % reported in this sentence appear to be only for the group with MHPs. Based on the sentence wording, the % for both groups need to be reported.

Comment [FC(]: Please double check number. Table reflects 33.8%

Comment [FC(]: My two cents: I think we should do more to raise attention to the fact that almost a quarter of both groups disclosed suicide intent. This is a true prevention opportunity so I think this is a common risk to highlight. Knowing space constraints, I think this is more important to highlight than the presence of a suicide note which often doesn't inform prevention. I suggest adding into results and into discussion.

Comment [FC(]: I feel that MMWRs typically don't do a lot of repeat of the specific data findings in the discussion. I think the numbers could come out here. I think it would be helpful to put this into a larger context, indicating whether this is consistent with other research. I also

Comment [BE(]: I would add the percentage in parenthesis (X%).

People with known MHP also experienced other life stressors such as job and/or financial~~, problems,~~ relationship ~~problems~~, and/or physical health problems. These findings point to the need to both prevent the conditions associated with mental health problems in the first place and the need to support people with known MHP to decrease their vulnerability to poor social, health, and economic outcomes [13].

These results underscore the importance of comprehensive statewide suicide prevention activities that go beyond a focus on ~~MH~~mental health treatment alone. Prevention strategies may include: strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills, especially early in life to manage everyday stressors and prevent future relationship problems; and promoting social connectedness to increase a sense of belongingness and access to informational, tangible, emotional, and social support~~, as needed~~. Other strategies ~~indicated by these results~~ include creating protective environments (e.g., reducing access to lethal means among people at risk, creating organizational and workplace policies to promote help-seeking and positive social norms), supporting family and friends after a suicide ~~has taken place~~, and assuring safe reporting by the media in order to prevent suicide contagion [11]. Some states, such as Colorado, are planning and implementing a comprehensive statewide approach to suicide prevention [14].

The ~~study~~ findings have at least three limitations. In the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent, or by decreased percentages of such deaths over time, which likely include some unrecognized suicides. Second, NVDRS is not yet nationally representative, and this study's ~~. This study used the most current data available which~~ data include~~des~~ 27 states that represent ~~half (~~49.6%~~)~~ of the U.S. population. Third, abstractors of NVDRS data are limited to data included in investigative reports. ~~For example, m~~Medical and ~~MH~~mental health information ~~are not captured directly from medical records but~~ come from key informants (e.g., family, friends) via coroner/medical examiner reports and can ~~. Therefore, informant knowledge~~ impact~~s~~ the data completeness and accuracy~~, of the information reported, and~~ Some studies including in-depth interviews with family members show ~~often see~~ greater attributions to ~~MH~~mental health and substance abuse disorders than medical records~~, however methodological variation across studies exists~~ [15]. It is likely that some people without known MHP in the current study were experiencing mental health challenges at the time of death that were either not known or reported by informants~~, or were not captured in NVDRS's primary data sources. The lack of awareness of a mental health problem suggests the importance of addressing the range of contributing circumstances~~.

Suicide is a growing public health problem. Mental illness is an important risk factor for suicide, and is one of many requiring preventive action. Data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices* [11] can help states and communities better understand their suicide problem and prioritize comprehensive suicide prevention.

Acknowledgments
The authors acknowledge Robert Anderson, Holly Hedegaard, and Margaret Warner from the Division of Vital Statistics, National Center for Health Statistics, CDC, for their statistical consultation.

Conflict of Interest No conflicts of interest were reported.

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Author Affiliations:

Comment [FC(]: I suggest pulling this out into a separate paragraph. If contained in the above, it seems to undercut the main point that many suicides don't have MPH. A new paragraph might need a lead-in sentence or maybe start with the current last sentence to frame points about common risks.

Comment [BE(]: Should this be 'and', 'or' or 'and/or'?

Comment [JRV8]: Suggest using "risk of" rather than "vulnerability to", as vulnerability sometimes can have negative connotations aligned with weakness.

Comment [FC(]: I think it is fine that the TP strategies are presented in different areas of the discussion. I don't easily see "identify and support people at-risk". I think that can go in the proposed paragraph immediately above when talking about common risk factors. In adding that, suggest adding some examples of approaches (e.g., crisis intervention, gatekeeper training).

Comment [FC(]: I am not easily following this point. Can this be stated more simply such as "…impacted by variations of undetermined injury deaths, which likely….

To help w/word count, offer a couple of suggestions in next few sentences to streamline. Certainly take/leave what you like and check for accuracy.

Comment [BE(]: Do you mean 'NOT' reported by informants?

Comment [FC(]: To me, this sentence puts the spotlight back on mental illness and makes it likely it will be the take home message of media reporting. If that isn't the goal of this VS, suggest framing broadly. Ideas: *Effective approaches are available to prevent or ameliorate many*

[1]Division of Violence Prevention, National Center for Injury Prevention and Control, CDC; [2]Division of Analysis, Research, and Practice Integration, National Center for Injury Prevention and Control, CDC

References:

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Tables and Figures (attachments)

Table 1 and Figure 1.doc

Tables 2 and 3.pdf

Word Count: 1826/1800

DRAFT

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

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†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

Comment [FC(]: Wonder if in a revised title or footnote if it needs to be revised to reflect this also includes District of Columbia.

Comment [FC(]: Suggest being clear on what these period, similar to how done in another footnote.

Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

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¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

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State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

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Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Differences between ranks do not necessarily imply a statistically significant difference.

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Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30)	+ 34.1 % (23)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3)	+ 46.5 % (4)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

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State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

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Figure 1.

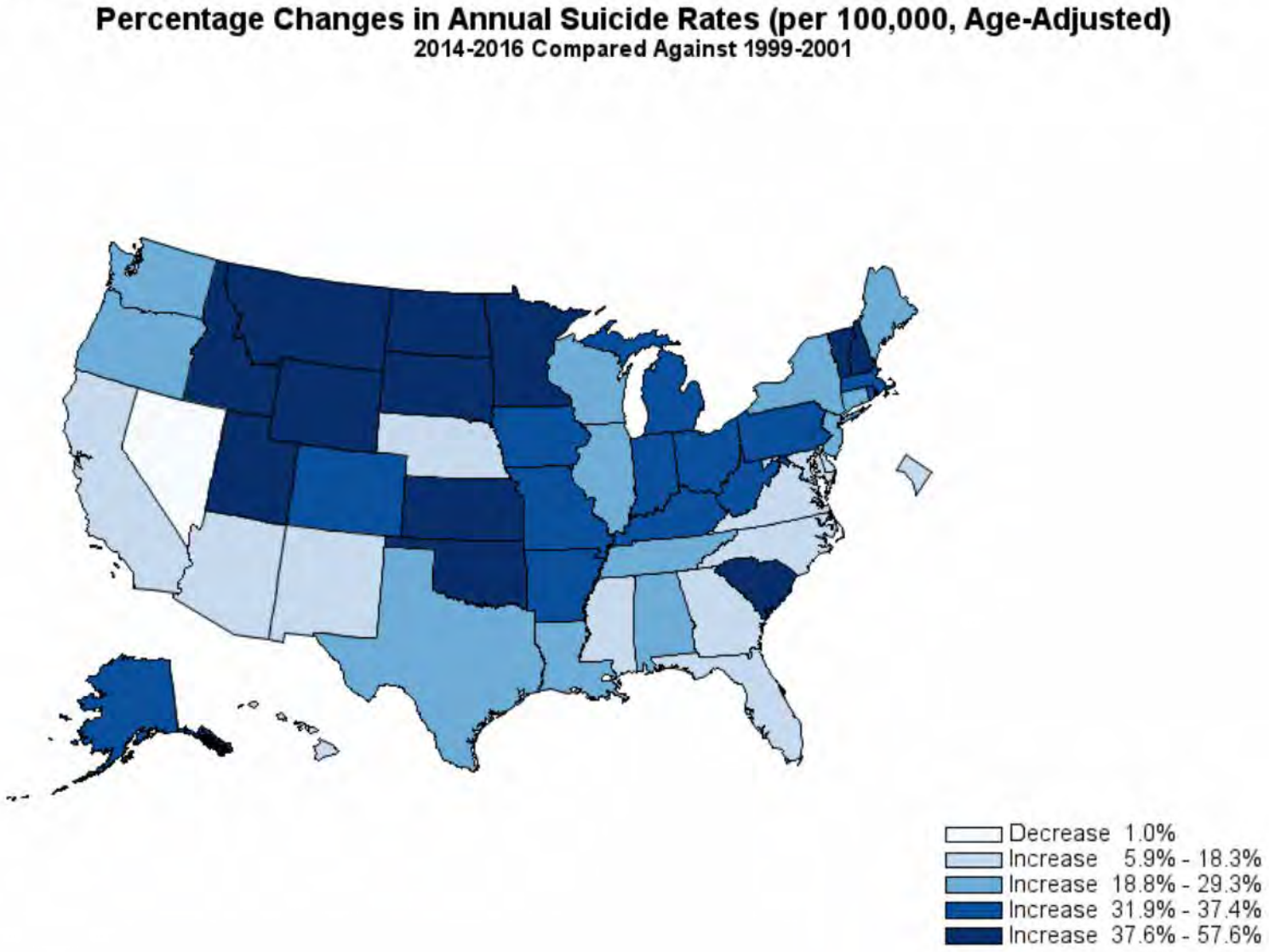

Percentage Changes in Annual Suicide Rates (per 100,000, Age-Adjusted)
2014-2016 Compared Against 1999-2001
Decrease 1.0%
Increase 5.9% - 18.3%
Increase 18.8% - 29.3%
Increase 31.9% - 37.4%
Increase 37.6% - 57.6%

Table 1. Select Demographic and Descriptive Characteristics of Suicides among Decedents >10 years of age with and without Known Mental Health Problems--National Violent Death Reporting System, 27 states*, 2015

Characteristics	Total (n=20,446)	Known Mental Health Problem† (n=9,407)	No Known Mental Health Problem (n=11,039)	Chi-Square	OR (95% CI)	Adjusted OR§ (95% CI)
Sex						
Male	15,702(76.8)	6,469(68.8)	9,233(83.6)	p<.01	2.3(2.2-2.5)	
Female	4,744(23.2)	2,938(31.2)	1,806(16.4)	p<.01	0.4(0.4-0.5)	
Age¶						
10-24	2,804(13.7)	1,211(12.9)	1,593(14.4)	p<.01	1.1(1.1-1.2)	
25-44	6,456(31.6)	3,036(32.3)	3,420(31.0)	p<.05	0.9(0.9-1.0)	
45-64	7,718(37.7)	3,820(40.6)	3,898(35.3)	p<.01	0.8(0.8-0.8)	
65+	3,468(17.0)	1,340(14.2)	2,128(19.3)	p<.01	1.4(1.3-1.5)	
Race/ethnicity						
White, non-Hispanic	17,102(83.6)	8,165(86.8)	8,937(81.0)	p<.01	0.6(0.6-0.7)	
Black, non-Hispanic	1,228(6.0)	411(4.4)	817(7.4)	p<.01	1.7(1.5-2.0)	
American Indian/Alaska Native, non-Hispa	378(1.8)	112(1.2)	266(2.4)	p<.01	2.0(1.6-2.6)	
Asian, non-Hispanic	576(2.8)	235(2.5)	341(3.1)	p<.05	1.2(1.1-1.5)	
Hispanic	1,096(5.4)	463(4.9)	633(5.7)	p<.05	1.2(1.0-1.3)	
Other	66(0.3)	21(0.2)	45(0.4)	p<.05	1.8(1.1-3.1)	
Extended demographics						
Ever served in military**	3,429(17.8)	1,354(15.3)	2,075(20.1)	p<.01	1.4(1.3-1.5)	1.1(1.0-1.1)
Homeless	240(1.2)	104(1.1)	136(1.3)		1.1(0.9-1.5)	1.2(0.9-1.5)
Incident Type						
Homicide followed by suicide	319(1.6)	64(0.7)	255(2.3)	p<.01	3.5(2.6-4.5)	2.9(2.2-3.8)
Single suicide	20,063(98.2)	9,318(99.1)	10,745(97.4)	p<.01	0.3(0.3-0.4)	0.4(0.3-0.5)
Method						
Firearm	9,909(48.5)	3,821(40.6)	6,088(55.3)	p<.01	1.8(1.7-1.9)	1.6(1.5-1.7)
Hanging/Strangulation/Suffocation	5,907(28.9)	2,940(31.3)	2,967(26.9)	p<.01	0.8(0.8-0.9)	0.8(0.7-0.8)
Poisoning	3,003(14.7)	1,861(19.8)	1,142(10.4)	p<.01	0.5(0.4-0.5)	0.6(0.6-0.7)
Substance class causing death††						
Other (e.g., over-the-counter)	1,021(34.0)	666(35.8)	355(31.1)	p<.01	0.8(0.7-0.9)	0.9(0.7-1.0)
Opioids	944(31.4)	608(32.7)	336(29.4)		0.9(0.7-1.0)	0.9(0.8-1.1)
Antidepressants	800(26.6)	644(34.6)	156(13.7)	p<.01	0.3(0.2-0.4)	0.3(0.3-0.4)
Benzodiazepines	624(20.8)	468(25.1)	156(13.7)	p<.01	0.5(0.4-0.6)	0.5(0.4-0.6)
Antipsychotics	219(7.3)	195(10.5)	24(2.1)	p<.01	0.2(0.1-0.3)	0.2(0.1-0.3)
Other	1,595(7.8)	780(8.3)	815(7.4)	p<.05	0.9(0.8-1.0)	0.9(0.8-1.0)
Toxicology Results						
Any toxicology testing	13,317(65.1)	6,658(70.8)	6,659(60.3)	p<.01	0.6(0.6-0.7)	0.7(0.6-0.7)
Positive for ≥ 1 substance§§	9,913(74.4)	5,192(78.0)	4,721(70.9)	p<.01	0.7(0.6-0.7)	0.8(0.7-0.8)
Substance detected***						
Alcohol						
Tested	10,950(53.6)	5,409(57.5)	5,541(50.2)	p<.01	0.7(0.7-0.8)	0.8(0.7-0.8)
Positive	4,442(40.6)	2,115(39.1)	2,327(42.0)	p<.01	1.1(1.0-1.2)	1.2(1.1-1.3)
Opioids						
Tested	8,554(41.8)	4,258(45.3)	4,296(38.9)	p<.01	0.8(0.7-0.8)	0.8(0.8-0.9)
Positive	2,279(26.6)	1,238(29.1)	1,041(24.2)	p<.01	0.8(0.7-0.9)	0.9(0.8-1.0)
Benzodiazepines						
Tested	8,124(39.7)	4,226(44.9)	3,898(35.3)	p<.01	0.7(0.6-0.7)	0.7(0.7-0.8)
Positive	2,464(30.3)	1,639(38.8)	825(21.2)	p<.01	0.4(0.4-0.5)	0.5(0.5-0.6)
Cocaine						
Tested	7,978(39.0)	3,866(41.1)	4,112(37.2)	p<.01	0.9(0.8-0.9)	0.9(0.9-1.0)
Positive	499(6.3)	216(5.6)	283(6.9)	p<.05	1.2(1.0-1.5)	1.2(1.0-1.5)
Amphetamines						
Tested	7,615(37.2)	3,696(39.3)	3,919(35.5)	p<.01	0.9(0.8-0.9)	0.9(0.8-0.9)
Positive	736(9.7)	376(10.2)	360(9.2)		0.9(0.8-1.0)	1.0(0.8-1.1)
Marijuana						
Tested	6,569(32.1)	3,127(33.2)	3,442(31.2)	p<.01	0.9(0.9-1.0)	0.9(0.9-1.0)
Positive	1,471(22.4)	710(22.7)	761(22.1)		1.0(0.9-1.1)	0.9(0.8-1.0)
Antidepressants						
Tested	5,425(26.5)	3,103(33.0)	2,322(21.0)	p<.01	0.5(0.5-0.6)	0.6(0.6-0.7)
Positive	2,214(40.8)	1,735(55.9)	479(20.6)	p<.01	0.2(0.2-0.2)	0.2(0.2-0.3)

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey,

† Decedent had been identified as currently having a diagnosed mental health problem in coroner/medical examiner or law enforcement reports.

§ Logistic regression was used to estimate adjusted odds ratio with 95% CIs after controlling for age, sex, race and ethnicity.

¶ Decedents were aged 10 years and older, as per standard in the suicide prevention literature.

** Denominator is decedents aged 18 years of age and older with reported military service status.

†† Denominator is decedents who died by poisoning, including overdose.

§§ Denominator is decedents with any toxicology tested.

*** Denominator for each positive group is the number tested for the substance in that group.

is an additional footnote needed on total or on the categories below to reflect why some don't add up to the overall total (e.g., age, incident type)

"single suicide" made me wonder about simultaneous or related suicides (ie more than one person), especially given this is available in NVDRS. Wonder if need another category for murder/related suicides or if the suicide suicide category should be renamed.

Considerable on both excel tables. "Currently having" feels odd to me since the individual is deceased. Could modify to something "having a current diagnosed mental health problem at time of death..."
Also think on both table examples or how MHP is defined is needed in the footnote to help the tables be interpretable independently from text

Table 2. Circumstances Preceding Suicide among Decedents ≥10 years of age with and without Known Mental Health Problems--National Violent Death Reporting System, 27 states*, 2015

Characteristics	Total	Known Mental Health Problem†	No Known MH Problem	Chi-Square	OR (95% CI)	Adjusted OR§ (95% CI)
Suicide with known circumstances	18,764(91.8)	9,407(100)	9,357(84.8)	p<.01		
Mental Health/Substance Problems						
Any Current Mental Health Diagnosis¶						
Depression/dysthymia	7,076(75.2)	7,076(75.2)				
Anxiety disorder	1,579(16.8)	1,579(16.8)				
Bipolar disorder	1,431(15.2)	1,431(15.2)				
Schizophrenia	509(5.4)	509(5.4)				
PTSD	424(4.5)	424(4.5)				
ADD/ADHD	226(2.4)	226(2.4)				
Unknown	760(8.1)	760(8.1)				
Current depressed mood	7,038(37.5)	3,962(42.1)	3,076(32.9)	p<.01	0.7(0.6-0.7)	0.7(0.6-0.7)
Substance Problems						
Any Current substance problem	5,319(28.3)	2,976(31.6)	2,343(25.0)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Alcohol problem	3,268(17.4)	1,862(19.8)	1,406(15.0)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Other substance problem	3,084(16.4)	1,768(18.8)	1,316(14.1)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Treatment						
Current mental health/substance abuse treatment	5,141(27.4)	5,077(54.0)	64(0.7)	p<.01	0.0(0.0-0.0)	0.0(0.0-0.0)
Ever treated for metnal health/substance problem	6,717(35.8)	6,323(67.2)	394(4.2)	p<.01	0.0(0.0-0.0)	0.0(0.0-0.0)
Relationship Problems/Loss						
Any relationship problem/loss	7,948(42.4)	3,726(39.6)	4,222(45.1)	p<.01	1.3(1.2-1.3)	1.3(1.2-1.4)
Intimate partner problem	5,098(27.2)	2,270(24.1)	2,828(30.2)	p<.01	1.4(1.3-1.5)	1.4(1.3-1.5)
Perpetrator of interpersonal violence past month	414(2.2)	131(1.4)	283(3.0)	p<.01	2.2(1.8-2.7)	2.0(1.6-2.4)
Victim of interpersonal violence within past month	84(0.4)	53(0.6)	31(0.3)	p<.05	0.6(0.4-0.9)	0.8(0.5-1.2)
Family relationship problem	1,671(8.9)	873(9.3)	798(8.5)		0.9(0.8-1.0)	1.0(0.9-1.1)
Other relationship problem (non-intimate)	403(2.1)	202(2.1)	201(2.1)		1.0(0.8-1.2)	1.1(0.9-1.3)
Argument or conflict (not specified)	2,914(15.5)	1,278(13.6)	1,636(17.5)	p<.01	1.3(1.2-1.5)	1.4(1.3-1.5)
Death of a loved one (any)	1,497(8.0)	826(8.8)	671(7.2)	p<.01	0.8(0.7-0.9)	0.9(0.8-0.9)
Non-suicide death	1,181(6.3)	647(6.9)	534(5.7)	p<.01	0.8(0.7-0.9)	0.9(0.8-1.0)
Suicide of family or friend	379(2.0)	217(2.3)	162(1.7)	p<.01	0.7(0.6-0.9)	0.8(0.7-1.0)
Other Life Stressors/Loss						
Any life stressors/loss	9,743(51.9)	4,675(49.7)	5,068(54.2)	p<.01	1.2(1.1-1.3)	1.1(1.1-1.2)
Recent criminal legal problem	1,588(8.5)	586(6.2)	1,002(10.7)	p<.01	1.8(1.6-2.0)	1.7(1.5-1.9)
Other legal problem	748(4.0)	378(4.0)	370(4.0)		1.0(0.8-1.1)	1.0(0.9-1.2)
Physical health problem	4,179(22.3)	2,012(21.4)	2,167(23.2)	p<.01	1.1(1.0-1.2)	1.0(1.0-1.1)
Job/Financial problem**	2941(16.2)	1530(16.8)	1411(15.6)	p<.05	0.9(0.8-1.0)	0.9(0.8-1.0)
Eviction or loss of home	722(3.8)	317(3.4)	405(4.3)	p<.01	1.3(1.1-1.5)	1.4(1.2-1.6)
School problem††	162(19.9)	70(17.8)	92(21.9)		1.3(0.9-1.8)	1.3(0.9-1.9)
Recent release from an institution§§	1,412(7.6)	941(10.2)	471(5.1)	p<.01	0.5(0.4-0.5)	0.5(0.4-0.5)
Jail/prison/detention facility	203(14.4)	82(8.7)	121(25.7)	p<.01	3.6(2.7-4.9)	4.5(3.2-6.4)
Hospital	517(36.6)	311(33.0)	206(43.7)	p<.01	1.6(1.3-2.0)	1.3(1.0-1.7)
Psychiatric hospital	432(30.6)	403(42.8)	29(6.2)	p<.01	0.1(0.1-0.1)	0.1(0.1-0.1)
Other psychiatric institution	37(2.6)	36(3.8)	1(0.2)	p<.01	0.1(0.0-0.4)	—¶¶
Residential facility (alc/SA treat)	80(5.7)	50(5.3)	30(6.4)		1.2(0.8-1.9)	—¶¶
Other	143(10.1)	59(6.3)	84(17.8)	p<.01	3.2(2.3-4.6)	3.1(2.2-4.5)
Crisis within past or upcoming two weeks***	5,525(29.4)	2,444(26.0)	3,081(32.9)	p<.01	1.4(1.3-1.5)	1.4(1.3-1.5)
Intimate partner problem crisis	1968(35.6)	854(34.9)	1114(36.2)		1.1(0.9-1.2)	1.1(0.9-1.2)
Physical health problem crisis	739(13.4)	315(12.9)	424(13.8)		1.1(0.9-1.3)	1.0(0.8-1.2)
Criminal legal problem crisis	621(11.2)	203(8.3)	418(13.6)	p<.01	1.7(1.5-2.1)	1.6(1.3-1.9)
Family relationship problem crisis	430(7.8)	212(8.7)	218(7.1)	p<.05	0.8(0.7-1.0)	0.9(0.7-1.1)
Job problem crisis	354(6.4)	191(7.8)	163(5.3)	p<.01	0.7(0.5-0.8)	0.7(0.5-0.8)
Suicide Event/History						
Left a note	6,468(34.5)	3,182(33.8)	3,286(35.1)		1.1(1.0-1.1)	1.2(1.1-1.2)
Disclosed suicide intent	4,405(23.5)	2,306(24.5)	2,099(22.4)	p<.01	0.9(0.8-1.0)	0.9(0.8-0.9)
History of ideation	5,990(31.9)	3,838(40.8)	2,152(23.0)	p<.01	0.4(0.4-0.5)	0.4(0.4-0.5)
History of attempts	3,732(19.9)	2,770(29.4)	962(10.3)	p<.01	0.3(0.3-0.3)	0.3(0.3-0.3)

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as currently having a diagnosed mental health problem in coroner/medical examiner or law enforcement reports.

‡ Logistic regression was used to estimate adjusted odds ratio with 95% CIs after controlling for age, gender, race and ethnicity.

§ Includes decedents with one or more diagnosed current mental health problems, which are not mutually exclusive. Therefore sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health problems.

**Denominator is decedents aged 18 years of age and older.

†† Denominator is decedents aged 10-18 years.

§§ Denominator of institution subgroup is decedents with recent realease from an institution.

¶¶ Results are not reported. Model failed to converge due to data separation.

***Denominator of crisis subgroup is decedents with any crisis within past or upcoming two weeks. Crises depicted here represent the most commonly occurring categories.

Typo in "release". Is is possible to also describe what recent means? Past two week or is this quite variable? Given the broad audience of MMWR, can this be put into more simple terms?

From: Sokler, Lynn (CDC/OD/OADC)
Sent: 6 Jun 2018 14:32:49 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Lenard, Courtney (CDC/ONDIEH/NCIPC);Dorigo, Leslie (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Simon, Thomas (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Gaines-McCollom, Molly (CDC/OPHPR/DEO);DeNoon, Daniel (CDC/OD/OADC) (CTR);Grusich, Katherina (Kate) (CDC/OD/OADC);Hoskins, Sharon (K.D.) (CDC/OD/OADC);Iverson, Dontae (CDC/OD/OADC);Balluz, Lina (ATSDR/DTHHS/OD);Bonds, Michelle E. (CDC/OD/OADC);Brand, Anstice M. (CDC/OD/CDCWO);Brown, Renee (CDC/ONDIEH/NCCDPHP);Bumpus, Stefanie (CDC/OID/NCEZID);Burden, Bernadette (CDC/OD/OADC);Burns, Annina (CDC/OD/CDCWO);Charles, Julia (CDC/OD/OCS);Clark, Cynthia K. (CDC/OD/OCS);Crawford, Carol Y. (CDC/OD/OADC);Daniel, Katherine Lyon (CDC/OD/OADC);Das, Mansi S. (CDC/OD/OADC);Dempsey, Jay H. (CDC/OD/OADC);Diaz, Shelly S. (CDC/OID/NCHHSTP);Dills, Kimberly C. (ATSDR/OPPE);DPAID (CDC);Dunn, Evelyn (CDC/OCOO/OFR/OA);Galatas, Kate (CDC/OD/OADC);Gonzalez, Belsie (CDC/OD/OADC);Grant, Llelwyn (CDC/OD/OADC);Green, Hugh (CDC/OD/OCS);Guest, Megan (CDC/OD/OADC);Heldman, Amy B. (CDC/OD/OADC);Hogg, Jarrad (CDC/OD/OADC);Hoo, Elizabeth (CDC/OD/PPEO);Iademarco, Michael (CDC/OPHSS/CSELS/OD);Joyner, Tonya (CDC/OSTLTS/OD) (CTR);Kelly, Alison (CDC/OCOO/OFR/OA);Kent, Charlotte (CDC/OPHSS/CSELS/DPHID);Knight, Dianna (CDC/OD/OADC);Knotts, Ashley (CDC/OD/OCS);Kroop, Seth (CDC/OD/OCS);Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD);Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD);McGowan, Robert (Kyle) (CDC/OD/OCS);Olivares, Dagny (CDC/OSTLTS/OD);Parikh, Sapana (CDC/OCOO/OFR/OA);Parker, Stacey M. (CDC/OSTLTS/OD) (CTR);Payne, Chelsea C. (CDC/OSTLTS/OD);Putman, Ami D. (CDC/OPHSS/CSELS/DLS);Rasmussen, Sonja (CDC/OID/OD);Redd, Stephen (CDC/OPHPR/OD);Redfield, Robert R. (CDC/OD);Schattner, Aimee (CDC/OD/CDCWO);Schindelar, Jessica (CDC/OD/OADC);Schuchat, Anne MD (CDC/OD);Simon, Gia M. (CDC/OSTLTS/OD);Smith, Patti (CDC/OD/OADC);Sokler, Lynn (CDC/OD/OADC);Sorrells, Marjorie J. (CDC/OD/OCS);Stanojevich, Joel G. (CDC/CGH/OD);Ware, Nina (CDC/OD/OADS);Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID);Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR);Wilson, Michelle (CDC/OCOO/OFR/OA)
Cc: Sokler, Lynn (CDC/OD/OADC);Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID);Peaker, Brandy (CDC/OPHSS/CSELS/DPHID);Omisore, Shannon L. (CDC/OD/OADC);Turner, Cheryl L. (CDC/OD/OADC) (CTR);Guest, Megan (CDC/OD/OADC);McGuire, Delaney (CDC/OD/OADC);Roberts, Ursula (CDC/OD/OCS) (CTR)
Subject: FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention
Attachments: DEAR COLLEAGUE_V2_5.15.18.13.02pm_rev_Final.DOCX, PRESS RELEASE_Suicide_VS_V6 _Final.docx, FACT SHEET_Vital Signs_June_2018_Suicide_Final_WEB.pdf, GRAPHIC_ PR_VS_June_2018_Suicide-Eng_v4_Final.pdf, TELEBRIEF SCRIPT_V6_06.6.18_206pm_pgmck_Final.docx, QA Document Suicide Vital Signs 6.5.18.docx, MMWR_Vital Signs_Suicide_6.7.2018_article.pdf

Hi Folks,
This month's issue of Vital Signs is on **Suicide Rates Rising across the U.S.** and releases **Thursday, June 7** with a Media Telebriefing at noon. **All materials go live on the CDC website at 1 pm**. Here are the key materials to use to distribute to stakeholders and partners: The Dear Colleague letter, MMWR, Fact Sheet, Press Release and Graphic.
For those distributing to media, please send the MMWR, Fact Sheet, Press Release and Graphic. Dr. Schuchat will be the primary spokesperson for this Vital Signs.

For those of you distributing out to partners and other constituents Thursday morning at 9 am, please make sure they know these are advance copies only. These materials are **embargoed until Thursday June 7 at 1 pm**. Please adjust the Dear Colleague letter for those people to which you send. Also please send Rich and me a copy when you email this out to your groups.

We will also have the press release on CDC en Espanol and available through the Vital Signs website.

For those attending the media telebriefing, I have also attached the Telebriefing Script and the Q&A document. **These do not get distributed externally**.

For each Vital Signs issue, we track and report on results **two times** – after 24 hours and after 30 days. We track the number of audiences reached (from all media and web sources), # of stories and type of media, the dollar value of the media coverage if CDC had to purchase it as advertising, social media use and reuse, and # of people looking at Vital Signs on our web pages.

Vital Signs reaches out to a lot of different people with our topics and, from our evaluation surveys, the uptake out in the field is impressive. In a survey, an astounding **95%** of state health officers and state epidemiologists were aware of and used VS issues, with about 3 in 4 using VS in the past year. All shared the material with their constituents via conference call, e-mail, newsletter, or mailing for topics appropriate to their members. A stratified random sample survey, used with NACCHO member organizations, reported that **74%** of all county or local health departments had heard of or used VS in the past year to educate staff, improve programs, and guide policy formation. As well, a 2017 internal evaluation showed that most program staff involved believe the value derived from it is worth the work, although producing Vital Signs takes a lot of effort.

I want to thank everyone who has worked on this issue for all their extra efforts. It's a very important topic and will be valuable information for many people. We hope that program continues to use this Vital Signs to promote its messages and the recommended actions in it to achieve new results.

Cheers,

Lynn

Lynn A. Solder|Senior Communication Advisor|Office of the Director|Office of the Associate Director for Communication| Centers for Disease Control and Prevention|Mailing: 1600 Clifton Road MS-E-69| Atlanta, GA 30329| zsz0@cdc.gov| office 404-498-6617 |bus. cell 404-409-5556|fx 404-498-0945



Dear Colleague:

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Tuesday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Web page to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Thank you for your support.

Debra Houry, MD, MPH
Director
National Center for Injury Prevention and Control

James A. Mercy, PhD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control

Press Release
Embargoed until 1:00 pm ET
Thursday, June 7, 2018
Contact: CDC Media Relations
404-639-3286

Suicide rates rising across the U.S.

Comprehensive prevention goes beyond a focus on mental health concerns

Suicide rates have been rising in nearly every state, according to the latest *Vital Signs* report by the Centers for Disease Control and Prevention (CDC).

In 2016, nearly 45,000 Americans age 10 or older died by suicide. Suicide is the 10th leading cause of death and is one of just three leading causes that are on the rise.

Suicide is rarely caused by a single factor. Although suicide prevention efforts largely focus on identifying and providing treatment for people with mental health conditions, there are many additional opportunities for prevention.

"Suicide is a leading cause of death for Americans – and it's a tragedy for families and communities across the country," said CDC Principal Deputy Director Anne Schuchat, M.D. "From individuals and communities to employers and healthcare professionals, everyone can play a role in efforts to help save lives and reverse this troubling rise in suicide."

Many factors contribute to suicide

For this *Vital Signs* report, CDC researchers examined state-level trends in suicide rates from 1999-2016. In addition, they used 2015 data from CDC's National Violent Death Reporting System, which covered 27 states, to look at the circumstances of suicide among people with and without known mental health conditions.

Researchers found that more than half of people who died by suicide did *not* have a known diagnosed mental health condition at the time of death. Relationship problems or loss, substance misuse; physical health problems; and job, money, legal or housing stress often contributed to risk for suicide. Firearms were the most common method of suicide used by those with and without a known diagnosed mental health condition.

State suicide rates vary widely

The most recent overall suicide rates (2014-2016) varied four-fold; from 6.9 per 100,000 residents per year in Washington, D.C. to 29.2 per 100,000 residents in Montana.

Across the study period, rates increased in nearly all states. Percentage increases in suicide rates ranged from just under 6 percent in Delaware to over 57 percent in North Dakota. Twenty-five states had suicide rate increases of more than 30 percent.

Wide range of prevention activities needed

The report recommends that states take a comprehensive public health approach to suicide prevention and address the range of factors contributing to suicide. This requires coordination and cooperation from every sector of society: government, public health, healthcare, employers, education, media and community organizations.

To help states with this important work, in 2017 CDC released a technical package on suicide prevention that describes strategies and approaches based on the best available evidence. This can help inform states and communities as they make decisions about prevention activities and priorities.

Everyone can help prevent suicide:

- Learn the warning signs of suicide to identify and appropriately respond to people at risk. Find out how this can save a life by visiting: www.BeThe1to.com
- Reduce access to lethal means – such as medications and firearms – among people at risk of suicide.
- Contact the National Suicide Prevention Lifeline for help: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org

The media can avoid increasing risk when reporting on suicide by:

- Following and sharing recommendations available at www.reportingonsuicide.org (for example, avoiding dramatic headlines or explicit details on suicide methods);
- Providing information on suicide warning signs and suicide prevention resources; and
- Sharing stories of hope and healing.

Vital Signs is a CDC report that typically appears on the first Tuesday of the month as part of the CDC journal *Morbidity and Mortality Weekly Report*. The report provides the latest data and information on key health indicators, and what can be done to drive down these health threats.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



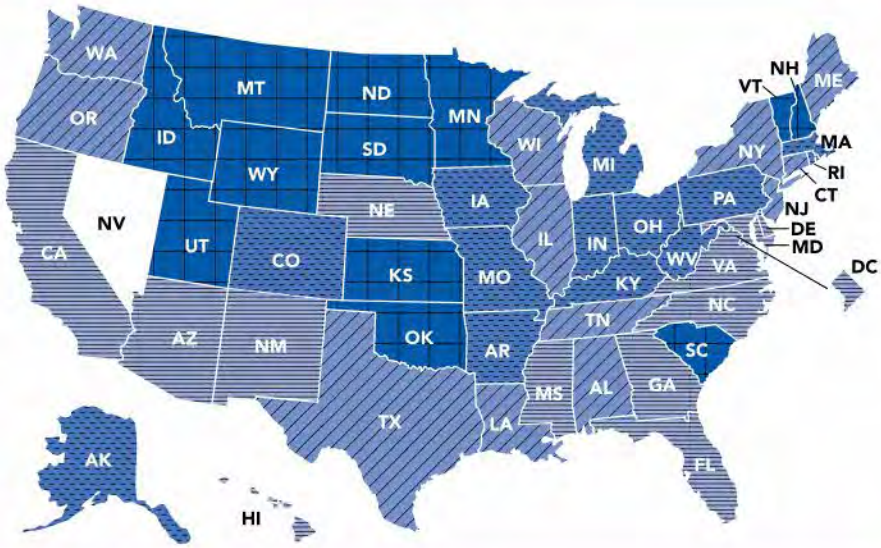
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

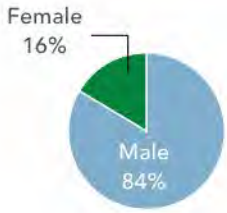


Differences exist among those with and without mental health conditions.

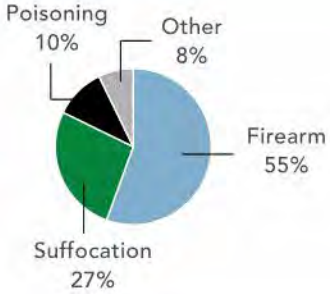
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

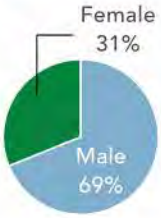


Method

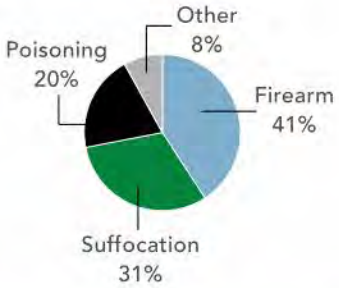


Known mental health conditions

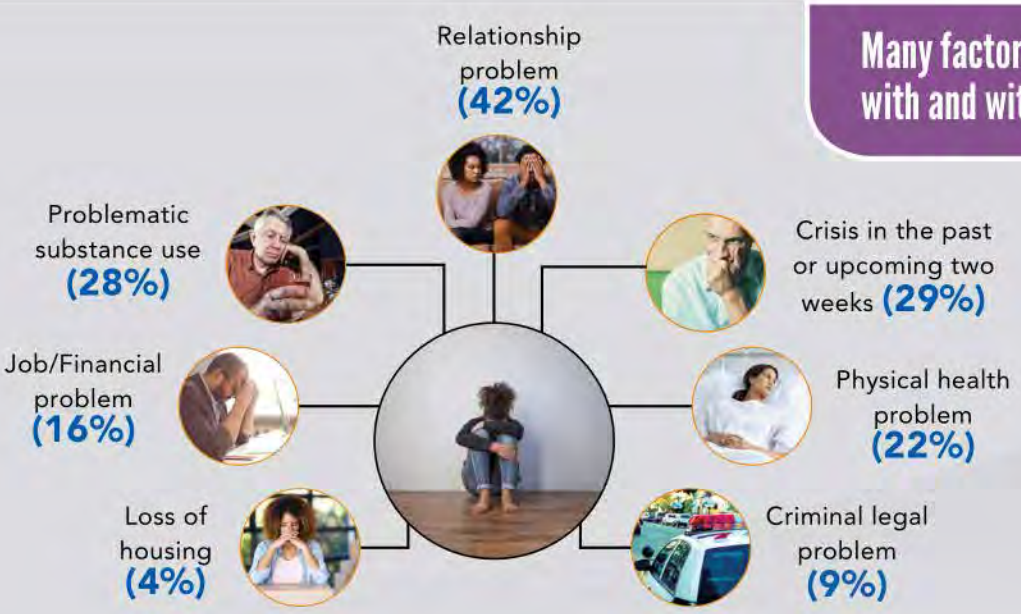
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

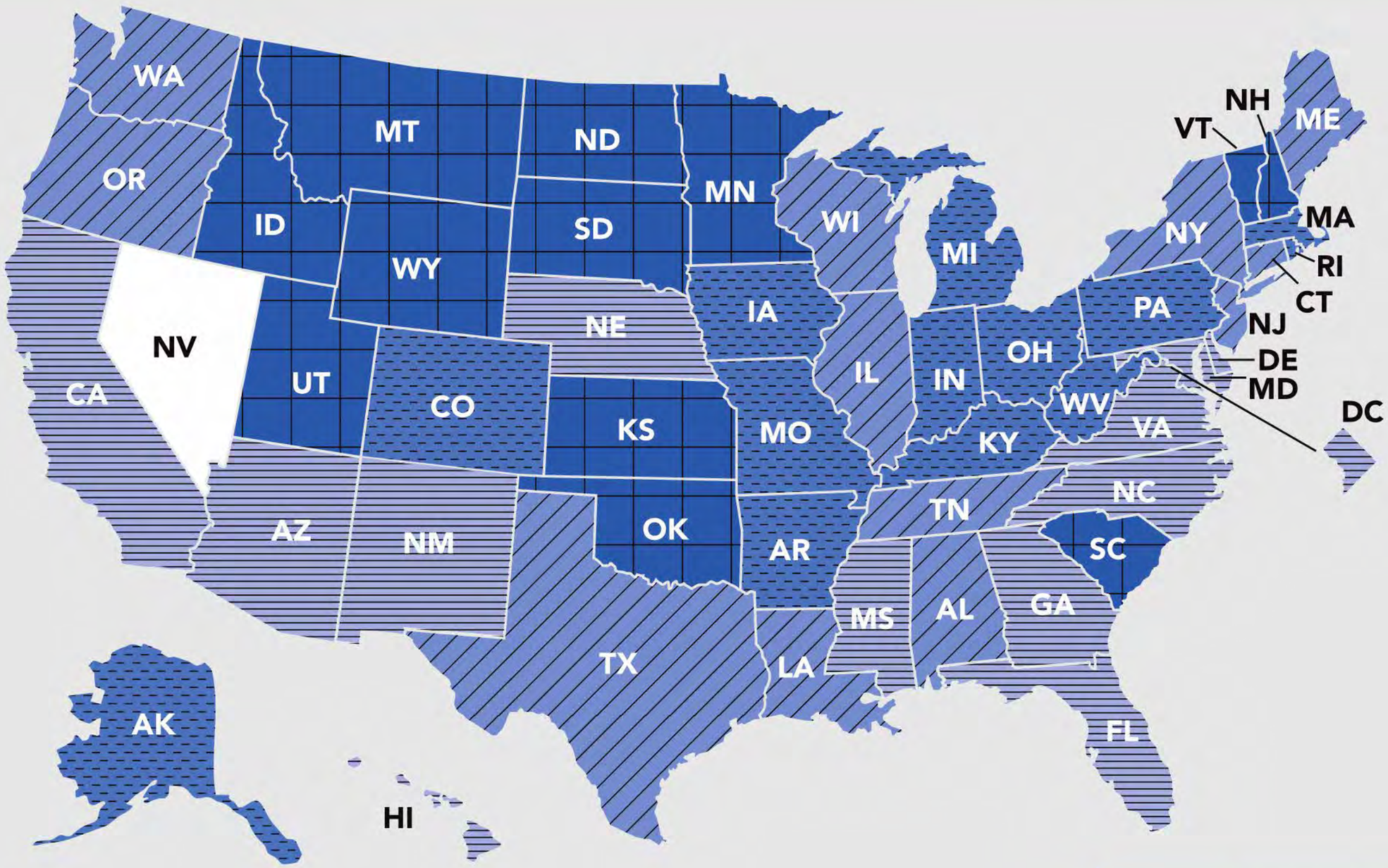
The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System.*

CDC Vitalsigns™

https://www.cdc.gov/vitalsigns/suicide

CS292322-C

Vital Signs Rising Suicide Rates Across U.S.

June 7, 2018

Desired Headlines

- Nearly 45,000 lives lost to suicide in 2016, but suicide is preventable.
- Suicide rates up in almost all states, but suicide is preventable.
- Suicide rates went up more than 30% in half of U.S. states between 1999 and 2016.
- Many factors contribute to suicide, beyond mental health conditions alone.

Moderator: Thank you (OPERATOR NAME). And thank you all for joining us today for the release of a new CDC Vital Signs report on Trends in Suicide Rates and contributing circumstances to suicide. We are joined by Dr. Anne Schuchat, CDC's Principal Deputy Director and Dr. Deb Stone, lead author of the study. Following opening remarks, Drs. Schuchat and Stone will respond to questions. I'll turn the call over now to Dr. Anne Schuchat.

Dr. Schuchat:

- Good afternoon and thank you for joining us today.
- CDC works 24/7 to protect Americans against health threats. Each month in CDC's *Vital Signs* report, **we focus on one of these threats – and what can be done about it**.

- Today's report contains **new information about state suicide trends, the factors that contribute to suicide, and the implications for prevention.**
- In 2016 alone, **45,000 people in the U.S. lost their lives to suicide.**
- Unfortunately, our data show that the problem is getting worse.
- Suicide is one of just three leading causes of death that are on the rise.
- And these statistics don't begin to reveal the emotional, social and financial toll that suicide exacts on individuals, families and communities who are left devastated.
- Many of us have lost friends, neighbors and family members to suicide – or have loved ones who have considered or attempted it.
- **Between 1999 and 2016, suicide rates increased among all age groups** younger than 75 years. During that period, middle-aged adults had the largest number of suicides and particularly high increases in rates.
- We found that **suicide rates increased in nearly every state** across the nation.
- **These findings are disturbing. Suicide is a public health problem that can be prevented.**
- For this *Vital Signs* report, we first analyzed data from the National Vital Statistics System to look at trends in suicide rates for all 50 states and Washington, D.C.
- We then looked at data from CDC's National Violent Death Reporting System (the NVDRS), which included information for 27 states in 2015, and looked at

circumstances around suicides among people with and without known mental health conditions.

  - [As a side note, CDC is now collecting data in 40 states, D.C. and Puerto Rico. And Congress has provided additional funding in the fiscal year 2018 omnibus so that CDC can expand the system to all 50 states].

- **Suicide is often attributed solely to a mental health concern. But, according to our data (NVDRS), fewer than half of the people who died by suicide had a known mental health condition.**
- Our research found that those people who died by suicide and ***did not*** have a diagnosed mental health condition were somewhat more likely than those *with* a mental health condition to struggle with **relationship problems or loss, other life stressors,** and experience **recent or impending crises**. However, and importantly, these circumstances were likely to occur in all people who died by suicide, regardless of whether or not they had a diagnosed mental health condition.
- **Suicide IS preventable.**
- That's why it's so important to understand the range of factors and circumstances that contribute to suicide risk, including **relationship problems, substance misuse, physical and mental health conditions, job issues, financial troubles, and legal problems.**

- With this information in mind, states and communities can develop a comprehensive approach to suicide prevention. One example of a successful program is **The United States Air Force Suicide Prevention Program**. This program, (which includes 11 policy and education initiatives designed to increase social support, social skills, and help-seeking) shifted the culture of the Air Force away from viewing suicide as an individual-oriented mental health concern to a larger, service-wide problem impacting the whole community. After the program was begun, the Air Force saw a 33% reduction in suicide as well as reductions in other related problems, such as severe family violence (54%) and homicide (51%).
- By increasing **awareness of the range of circumstances** contributing to suicide risk, and acting to address them through a comprehensive approach, we could reach our national goal of **reducing the annual suicide rate by 20 percent by 2025**.
- Today's report suggests we have a lot of important work to do to reach this goal. Nearly **all states had increasing suicide rates between 1999 and 2016, and 25 states had rate increases of more than 30 percent.**
- So how do we work together to reverse these numbers and help save lives?
- **On the Federal level, government agencies are tracking the problem of suicide to understand trends and groups at greatest risk;** developing, implementing, and

evaluating what works to prevent suicide in communities; supporting local, territorial, state, tribal, and other partners to prevent suicide; and working with public and private partners to advance the **National Strategy for Suicide Prevention.**

- In states and communities, close coordination of activities between public health agencies and other sectors of society is critical for preventing suicide. Necessary partners include health and mental healthcare providers, social services, first responders, educators, faith communities, and the media.
- States and communities ***can*** **and** ***should*** **take action now**.
- To help prioritize prevention, CDC developed *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* It features the best available evidence for states and communities to guide their prevention activities.
- Some of the strategies are designed to prevent suicide risk before it emerges in the first place. These strategies include teaching coping and problem-solving skills to help people manage life challenges; promoting safe and supportive environments, including safe storage of medications and firearms among people at risk; providing temporary help for people struggling to make ends meet; and encouraging connectedness so people are less likely to feel alone or isolated.

- Other strategies in the technical package are designed to support people who may already be struggling, by providing effective treatment and crisis intervention strategies.

- Health and behavioral health care providers have an important role to play in suicide prevention as well, so that nobody in these systems falls through the cracks. Policies and protocols that prioritize patient safety and that help get people into ongoing care, especially during care transitions, can help prevent suicide.

- Last and very important, the technical package describes approaches to prevent future suicide risk among people who have attempted suicide or have lost a friend or loved one to suicide.

- You can find the link to the technical package is on our *Vital Signs* website.
- **Preventing suicide takes everyone. Parents, employers, teachers, coaches, religious leaders, healthcare providers, and people affected by suicide – everyone in the community** can help prevent suicide risk by learning the warning signs of suicide and how best to respond effectively. **Together we can work to bring hope and save lives.**

Suicide Prevention Vital Signs Q&As

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General Background on the Problem of Suicide

- **Suicide is a public health problem.**
  - Nearly 45,000 lives were lost to suicide in 2016, which is approximately one suicide every 12 minutes.
  - Rates have increased by nearly 30% from 1999-2016 (28.1%)
  - Suicide rates vary by race/ethnicity, age, and other population characteristics, with the highest rates across the lifespan occurring among non-Hispanic American Indian/Alaska Native (AI/AN) and non-Hispanic White population groups, middle-aged adults, veterans and active duty personnel, certain occupational groups, and sexual minority youth.
  - More than half of suicide deaths occur among adults in the prime of their lives, ages 35-64.
  - Suicide rates in rural areas are consistently higher than rates in more urban areas.
  - Suicide and nonfatal self-harm injuries cost more than $69 billion annually in direct medical and work loss costs.

- Decades of research have shown that suicide is preventable.

What was the impetus for this study?

1. What was the impetus for this study?

The CDC has a strong portfolio of research describing the increasing trends in suicide as well as rich data on circumstances contributing to suicide from the National Violent Death Reporting System. CDC also has a technical package geared towards states and communities that provides what works to prevent suicide based on the best available evidence.

With all of this information in hand and in the context of increasing national suicide rates, the present study was motivated to support states and our nation as we seek to meet the national goal of reducing annual suicide rates 20% by 2025.

2. A CDC employee went missing in February and was later found deceased. His death was determined to be suicide. Is that why you're publishing this study now?

The CDC community continues to be deeply saddened and impacted by the death of Commander Cunningham. As you correctly state, his death was recently ruled a suicide by the Medical Examiner's office. While it's true the timing of our study is close to Commander Cunnigham's death, this study began many months before Commander Cunningham disappeared.

CDC has worked to prevent suicide for many years and suicide prevention is currently a priority area. We have a strong portfolio of research describing the increasing trends in suicide and rich data on circumstances contributing to suicide from the National Violent Death Reporting System. CDC also has a technical package geared towards states and communities that provides what works to prevent suicide based on the best available evidence.

With all of this information in hand and in the context of increasing national suicide rates, the present study was motivated to support states and our nation as we seek to meet the national goal of reducing annual suicide rates 20% by 2025.

What is CDC doing to prevent suicide?

3. Has CDC provided states resources to prevent suicide? Who in the state does this work?

CDC does not provide direct funding to states to conduct suicide prevention work specifically, as CDC has no appropriation for suicide prevention.

However, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides grants to states, tribal communities, and campuses through its Garrett Lee Smith, National Strategy, and Zero Suicide grant programs.

CDC funds 23 state health departments through the Core State Violence and Injury Prevention Program, which helps states implement, evaluate, and disseminate strategies to prevent injuries and violence. Some of the states funded under this initiative are focusing their efforts on suicide prevention.

The CDC also funds ten Injury Control Research Centers (ICRCs). These centers study ways to prevent injuries and violence and work with community partners to put research findings into action. Four of the currently funded ICRCs are working to prevent suicide through research, training, or outreach activities: University of Iowa, University of North Carolina at Chapel Hill, University of Rochester, and West Virginia University.

CDC has also created a technical package for suicide prevention that states and communities can use to inform and guide their prevention efforts.

4. What is CDC doing to prevent suicide?

The CDC takes a public health approach to preventing suicide, which involves a number of steps. CDC is:

- **Tracking and monitoring trends** in suicide and suicide attempts to inform prevention policies and programs (for example--)
    - Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. MMWR Morb Mortal Wkly Rep 2018;67:237–242.
- **Identifying risk and protective factors**; and developing evidence-based prevention programs.
    - **Developing an environmental scan of all 50 states, D.C., territories, and select tribes (STTs)** to gain a greater understanding of what factors at the STT-level may be associated with rising suicide rates (e.g. lack of suicide prevention infrastructure, prevention activities, legislation passed, partnerships/collaborations, barriers & facilitators to suicide prevention).
- **Evaluating programs**, policies, practices to determine if they prevent suicide risk.
    - **Currently evaluating two RCTs** with interventions focused on middle-aged males. These projects are in year 3 of 4 currently so results are not yet available. One project uses a multi-media program in the waiting room to help men at high-risk to raise their suicidal thoughts with their primary care clinicians. The second project evaluates the impact of mantherapy (www.mantherapy.org), an intervention designed specifically males that uses humor and male stereotypes to get across messages on suicide prevention, plus screening for mental health resources compared to just screening for mental health resources
- **Sharing information about the best available evidence** (for example, the suicide prevention technical package).

New projects (Also included on page 32-33)

- **Linking NVDRS with Departments of Defense and Veterans Affairs data on suicide**

- Partners who are working on this project include Department of Veterans Affairs, Department of Defense Suicide Prevention Office, and the Psychological Health Center of Excellence/Defense Health Agency.
- This project will link pertinent data on active duty Military and Veteran suicide decedents across CDC's National Violent Death Reporting System (NDVRS), the Department of Defense Suicide Event Reports, and the Veteran Health Administrative databases.
- Provide more information on suicides among active duty Military personnel and Veterans as well as partition study populations in the NVDRS (e.g., civilians, active duty, VHA Veterans, non-VHA Veterans).
- Help agencies monitor common and unique precipitating factors of suicide captured in NVDRS by group/population and inform comprehensive community-based efforts to help address specific population needs. All linkages will use a de-identified matching technique. No personal identifying information will be used.

- **Social media intervention**
  - The purpose of this project is to implement, test, and refine a web-based peer-to-peer therapeutic support platform for U.S. Military Veterans aimed at preventing suicide and related problems.
  - This system called TalkVet, has the potential to bridge the gap between the many social media sites that are widely used by Veterans (e.g., Facebook, Snapchat, etc.) and the growing number of clinical interventions that are available to Veterans, but currently under-utilized.
  - With the explicit consent of users, we will test the novel features of the TalkVet platform in three ways:
    1. Use an artificial intelligence (AI) guided system to help identify participating Veterans most in need of help based on their posts and other user activity;
    2. Connect Veterans in need of help with other Veterans in TalkVet who can support them; and
    3. Conduct outreach with experimentally refined methods for Veterans in need of a higher level of care to encourage them to obtain such care in the form of links and hand-offs provided by the TalkVet system (this phase of the work will include the use of Veteran moderators with training in crisis counseling who will work with our team).
  - This project includes partners from Harvard University, West Virginia University ICRC, TalkLife/Talk/Vet and has been approved by CDC-F.

- **Colorado Collaborative for a Comprehensive Approach to Suicide Prevention**
  - The CDC is collaborating with the Colorado Department of Public Health and Environment, the CDC-funded Injury Control Research Center (ICRC-S), the Colorado National Collaborative (CNC), and the Colorado Suicide Prevention Commission on the first state-wide, large-scale, population-based initiative to reduce suicide rates 20% by 2024 in CO and to serve as a model for other states to help reduce suicide by 20% by 2025 in the nation. Partners on the CNC also include the Action Alliance, SAMHSA, and AFSP, among others.
  - Through this project we propose to pilot test the implementation and evaluation of a comprehensive, integrated approach to suicide prevention—guided, in part, by the CDC's technical package and the National Action Alliance for Suicide Prevention's (NAASP) *Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention*.
  - Working with CDC/F to seek external funding
  - Why Colorado?
    - Colorado consistently ranks among the states with the highest suicide rates in the nation (rate: 19.5 per 100,000 in 2015—U.S. rate 13.3 per 100,000).

- Colorado has sizable populations at increased risk of suicide, including veterans, American Indian/Alaska Natives (AI/AN), and people living in rural communities.
- Colorado demonstrates readiness as evidenced by a strong state suicide prevention infrastructure, a history of political will, and a proven track record of valuing and implementing public health approaches to prevention. Specifically, the State has:
    - A funded Office of Suicide Prevention (OSP; legislated in 2000)
    - Suicide Prevention Commission (legislated in 2014)
    - Colorado National Collaborative (est. 2015)
    - A strong platform of existing suicide prevention activity
    - A commitment to 'connecting the dots'/shared risk and protective factors

*The CDC Foundation is seeking funds from donors to support this work. It is also partially funded by a grant from SAMHSA and other state and local resources (to a small degree).

Why are suicide rates increasing?

5. Why are suicide rates increasing?

While the Vital Statistics data are great for describing trends they don't tell us about the causal factors that are driving the increases.

We do know that suicide is not caused by one factor, but instead, it is typically caused by a combination of individual, relationship, community, and societal factors.

Several such factors could be contributing to the increases:

Economic conditions

The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability could have contributed to increases in suicide risk. Past research on the association between business cycles and U.S. suicide rates indicates that the overall suicide rate rises and falls in connection with the economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.

Opioid epidemic

Increased availability and misuse of prescription opioids may be related to increases in suicide rates. Substance misuse itself is an established risk factor for suicide and, therefore, opioid misuse associated with the opioid overdose epidemic could be driving the suicide rate higher. When we look at who is dying from suicide and who is dying from unintentional overdoses involving opioids, we see that there is overlap in the demographics of the populations most highly affected by suicide and unintended opioid overdose deaths. Data also indicate that opioid prescribing rates are higher in counties where there are higher rates of suicide.

Social media

More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

Rural

While there have been increases and decreases in rates over time, research shows that rates across cities and towns in the United States have been rising, with rural areas experiencing the most increases. The increased rates may be associated with suicide risk factors that are more common in less urban areas, such as limited access to mental healthcare as well as greater social isolation.

Bridge to:

Although the reasons for the increases in suicide rates are not fully understood, we do know a lot about the circumstances that contribute to suicide risk. It is clear that many factors contribute to suicide beyond mental health factors alone.

- These factors include such things as relationship problems (e.g. relationship loss through death, divorce, or break-up; arguments, interpersonal violence), problematic substance, physical health problems, job/financial problems, and legal problems.

6. Why are suicide rates increasing so much in Western states?

Suicide rates have consistently been higher in Western states and these data show that several Western states have seen substantial increases in suicide rates. While the reasons for this need additional study, research has shown that suicide rates have increased faster in rural areas, which may explain some of the difference. Also, the timing of the increase seems to coincide with the Great Recession. Though the recession is over, rural areas were disproportionately impacted and have had a slower recovery time. Others have also pointed to social isolation and access to mental and behavioral health treatment as potential contributing factors to the higher suicide rates in Western states.

7. Why are suicide rates increasing more in less urban (or more rural) areas?

While there have been increases and decreases in rates over time, research shows that rates across cities and towns in the United States have been rising, with <u>rural areas experiencing the greatest increases</u>.

- **Increased rates may be associated with suicide risk factors that are more common in less urban areas**,
  - Limited access to mental healthcare
  - Greater social isolation.

        - **Loss of jobs, homes, and income associated with the Great Recession as well as the prescription opioid overdose epidemic**, which has had a greater impact on less urban areas.
    - Urban areas may also experience these risk factors, but to a lesser extent.

8. During the Great Recession, there was an increase in suicide, but why are rates still going up since the economy has bounced back?

Suicide rates have continued to rise after the Great Recession.

A previous study found that suicide rates across all urbanization levels in the U.S. increased over the period from 1999-2015, but the gap in rates between less urban and more urban areas widened over this period, and rates in more rural areas increased at a more rapid pace than more urban areas beginning in 2007-2008.

The rapid acceleration of increasing suicide rates in more rural areas in 2007-2008 may reflect the corresponding start of the Great Recession at about this same time.

- **The disproportionate impact of the recession on rural areas and the longer economic recovery time in these areas may help to explain why suicide rates have remained high overall.**
- Other common suicide risk factors including mental health and substance use problems may be exacerbated in rural areas potentially influenced by the prescription opioid overdose epidemic , poor access to mental healthcare, made worse by shortages in behavioral health care providers in rural areas, and greater social isolation in rural areas.

The potential cumulative burden of suicide risk factors in less urban areas may impact not only individuals but relationships, families, and communities as well, suggesting the need for comprehensive suicide prevention measures.

9. Is the opioid overdose epidemic associated with rises in suicide rates?

Both suicide and drug overdoses are on the rise. CDC is actively working to analyze and better understand the trends and risk factors for opioid overdose and suicide, and the connections between the two public health challenges.

Increased availability and misuse of opioids may be related to increases in suicide rates. Substance misuse itself is an established risk factor for suicide and, therefore, opioid misuse associated with the opioid overdose epidemic could be driving the suicide rate higher. When we look at who is dying from suicide and who is dying from unintentional overdoses involving opioids, we see that there is overlap in the demographics of the populations most highly affected by suicide and unintended opioid overdose deaths. Data also indicate that opioid prescribing rates are higher in counties where there are higher rates of suicide.

CDC uses several systems to monitor overdoses, overdose deaths & suicide:

- Deaths – Death certificates, National Violent Death Reporting System (NVDRS) and State Unintentional Drug Overdose Reporting System (SUDORS)
- Nonfatal – National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP), Healthcare Cost and Utilization Project from AHRQ, and emergency department syndromic/medical claims and EMS surveillance data from CDC's Enhanced State Opioid Overdose Surveillance program

10. Why are suicide rates increasing more among females?

This study showed that suicide rates were increasing for females and males. The increases for females were significant in 43 states and the increases for males were significant in 34 states. It is important to note that while the relative increases in rates were higher for females than for males overall, the absolute suicide rates rose faster for males than females. Male suicide rates are consistently 3 to 5 times higher than the suicide rates for females. It is important for suicide prevention strategies to address the needs of males and females.

While the Vital Statistics data can be used to describe such trends, these data cannot tell us about the causal factors that are driving the increases. We do know that suicide is not caused by one factor, but instead, it is typically caused by a combination of individual, relationship, community, and societal factors.

11. A paper came out recently about county-level trends in suicide rates in the US from 2005-2015, how do the results of that study compare with the results from the Vital Signs?

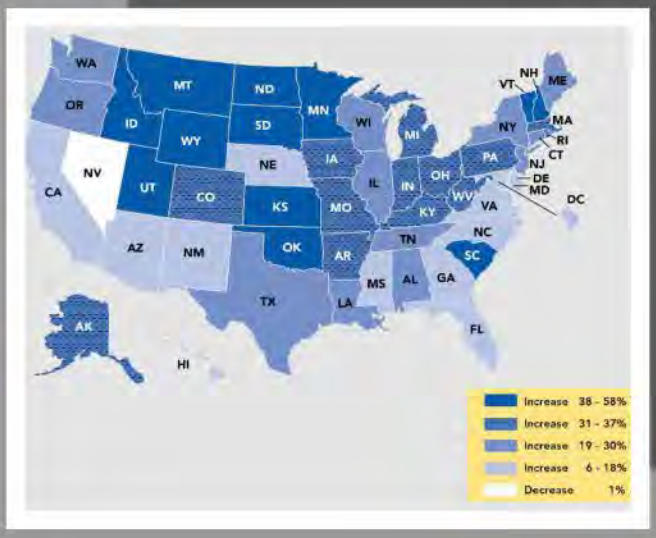
That paper and the VS both look at trends in suicide rates over time, however, this month's VS examines state-level trends in suicide rates whereas the other examines county-level trends. Despite this difference in the level of analysis undertaken (state vs county), both articles point to the same sobering conclusion that rates of suicide at both the state and county level have increased. States may use both sets of findings to tailor comprehensive suicide prevention to areas most impacted by suicide. CDC's technical package inclusive of the best available evidence to prevent suicide is an important resource that can benefit both states and local communities.

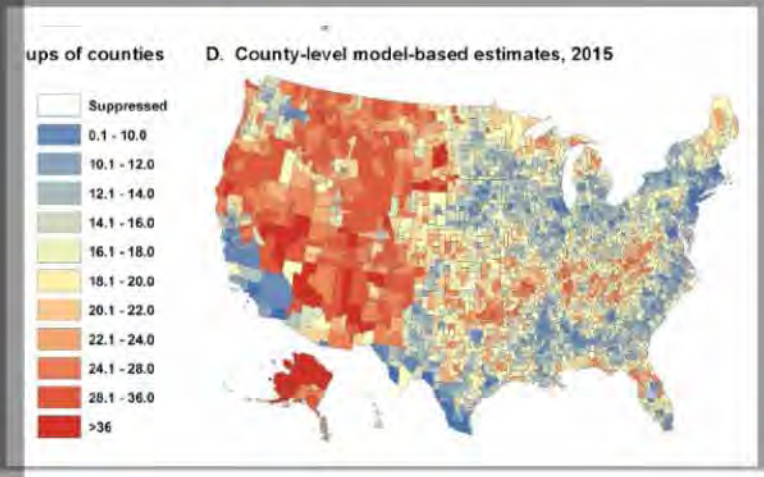
Note: Some counties with the highest and lowest rates of suicide do not align with our map, and in some cases, they contradict each other. This is because our map shows *percentage increases* in suicide rates over time at the state level vs. aggregated average rates of suicide over time at the county level as presented in the study by Rossen and colleagues.

County level suicide prevention paper (Rossen et al., 2018) compared to VS

	County paper	VS
Dates for analysis	2005-2015	1999-2016

Level of analysis	County	State
Increases in suicide rates	>10% for 99% of counties >20% in 87% of counties >30% in 34% of counties	Average 25.4% across states Range 6-58% increases >30% increase in half of states
Regions of highest increase	West and Northwest	Western states/Midwest
Rural vs Urban	Rural has highest rates	Didn't analyze
Rates	4.76 to 64.16	
Highest rates	Counties in AK, AZ, CA, CO, **ID,** MT, NM, NV, **ND, SD**, OR, **WY**	**ND**, VT, NH, UT, KS, **SD**, **ID,** MN, **WY**, SC
Lowest rates	Counties in **CA**, CT, MA, NY, RI, NJ, TX, **NC**, SC	DE, MD, FL, **NC, CA**, DC, GA, NE, AZ, VA, MS





12. Are part of the increases in suicide rates being driven, or impacted, by cases of physician assisted-suicide?

No. The suicide rates increases observed in this study are not related to cases of physician-assisted suicide. Physician-assisted suicide is currently legal in just a handful of states and such deaths are not classified as suicide.

13. Does CDC endorse or support physician-assisted suicide?

CDC does not take a stand, either for or against, physician-assisted suicide.

What's going on globally with respect to suicide rates?

14. How does the U.S. compare to other nations with respect to trends in suicide rates?

Globally, suicide rates have been declining.

Global data from the World Health Organization indicates that nearly all European societies experienced rising suicide rates after the Great Recession. However, unlike the U.S., the suicide rate in many European nations stabilized or returned to pre-recession levels after the recession. This may be because the economic recession impacted different countries in different ways, and areas within the U.S. may have taken longer to recover from the recession.

Although suicide rates also increased in Canada during the Great Recession, Canada has experienced a fairly level suicide rate over the past 17 years, with a rate between 12.5 to 13.0 per 100,000.

Unlike in the U.S., ingestion of pesticide is one of the most common methods of suicide globally. Policies related to the sales and import of pesticides, which have reduced access to this lethal means of suicide, have demonstrated impact in preventing suicide in some countries. For instance, in Sri Lanka, the suicide rate decreased from 47 per 100,000 in 1995 to 30.9 per 100,000 in 2005 after the implementation of such policies.

15. What's going on in the U.S. that's not occurring in other countries to explain the increase in suicide rates here?

The U.S. has good surveillance systems in place to track mortality, allowing us to identify the increases in suicide rates and even which areas of the country, age groups, and racial/ethnic groups are most at risk. Unfortunately, these surveillance systems do not assess and track the risk factors that may be contributing to these trends.

We know that ***suicide rates are increasing in most age groups and demographic groups and we are seeing increases across suicide methods***.

The increases in suicide rates are unlikely to be due to any single factor. Factors at the individual, relationship, and community levels - such as a prior suicide attempt, age; substance abuse history; school, job, or legal problems; exposure to another person's suicidal behavior; and the accessibility of assistance in the community all contribute to risk.

It is likely that multiple factors are influencing suicide trends.

16. Last year, Hurricanes Irma and Maria caused a great deal of both distress and fatalities in PR. Do we know how many of these deaths were suicide? How can we prevent these in the future?

Final data from Puerto Rico on the number of suicides is not yet available. CDC is collaborating with the Commission for Suicide Prevention at the Puerto Rico Department of Health in an effort to prevent suicide, increase awareness about factors that increase and decrease suicide risk, and to conduct training of healthcare providers and others in the community. CDC is also translating Preventing Suicide: A Technical Package of Policy, Programs, and Practices into Spanish. This document helps communities to prioritize prevention activities based on the best available evidence.

Firearms and Suicide

17. Are firearms a major means of suicide globally?

Unlike in the U.S., ingestion of pesticide and hanging are the two most common methods of suicide globally.

Policies related to the sales and import of pesticides, which have reduced access to this lethal means of suicide, have demonstrated impact in preventing suicide in some countries. For instance, in Sri Lanka, the suicide rate decreased from 47 per 100,000 in 1995 to 30.9 per 100,000 in 2005 after the implementation of such policies.

18. How many lives are lost to firearm-related suicides per year?

In 2016, almost 23,000 lives were lost due to suicides by firearm. This equates to 51% of suicides in the U.S. in 2016.

19. Does the CDC want to restrict access to firearms?

The CDC is *not* suggesting that firearms should be taken away from U.S. residents.

An important function of public health is to prevent injury and death. Given the lethality of firearms, it is important to identify ways to prevent them from being used for self-harm. Based on prior research, **we know that safe storage practices can help reduce the risk for suicide by separating people at-risk, or who have made prior attempts, from easy access to lethal means.** This can involve safely storing firearms locked and unloaded in a secure place (e.g., gun safe or lock box) and separate from ammunition. This can help to provide a buffer for those who are thinking about suicide and increases the time it takes them to access lethal means. **We know from prior research that simply providing a buffer in this critical time period can help reduce risk.**

20. What are the leading ways that people die by suicide?

Firearms are the mechanism for about half of all suicides in the United States.

The next leading methods are suffocation and poisoning.

Reducing access to lethal means of suicide among persons at risk for suicide is an intervention with robust supporting evidence; such intervention includes:

- Intervening at suicide hotspots such as bridges
- Counseling around safe storage of medications, firearms, or other household products to keep them away from people at risk.
- **These interventions can be combined with other strategies for a comprehensive approach to prevention.**

21. What was the process of obtaining support and resources from the CDC to do this research, given the agency's historical lack of funding for gun violence research?

This study used data from existing public health surveillance systems that collect data on many different causes of injury and death. CDC has, and continues to, support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impacts of firearm-related injuries is an important step toward prevention.

22. A previous report shows that a substantial number of gun-caused deaths are suicides. What could drive children to take their own lives and how do they access firearms in the first place?

When looking at the circumstances surrounding child firearm suicides, while mental health factors are important, firearm suicides are also frequently related to situational life stressors and relationship problems with an intimate partner, friend, or family member. It is important for parents and other adults who interact with children to be aware that life stressors such as these can have a big impact on children and put them at risk for suicide.

Other researchers have found that safe storage of firearms (storing firearms locked, unloaded, and separate from ammunition) is associated with reductions in adolescent firearm suicide attempts and also unintentional firearm deaths in children.

The Present Study - MMWR Content and Methods

23. How was the current study conducted?

Trends in age-adjusted suicide rates were assessed among people aged ≥10 years, by state and sex, and across six consecutive three-year periods (1999-2016), using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among suicide decedents with and without known mental health conditions.

24. What are some of the key findings?

- Across the study period, **suicide rates increased in all states, except Nevada** (which had a consistently high rate throughout).
    - These increases were statistically significant in 44 states.
    - The percentage increases in rates ranged from 5.9% in Delaware to 57.6% in North Dakota, with increases of more than 30% observed in 25 states.
- Suicide rate trends indicated significant increases for males (34 states) and females (43 states), as well as for the U.S. overall.

- While all decedents were predominately male (76.8%) and non-Hispanic white (83.6%), **those without known mental health conditions, relative to those with mental health conditions, were more likely to:**
    - be male (83.6% vs. 68.8%; odds ratio (OR)=2.3, 95% CI = 2.2-2.5)
    - be racial/ethnic minorities (OR range: 1.2-2.0)
    - to die by firearms (OR=1.6, 95% CI= (1.5-1.7).
- Overall, **the large majority of suicides occurred among people ages of 25-64**.
- **More than half of suicide decedents in NVDRS (27 states) did *not* have a known mental health condition.**
    - This group suffered more from relationship problems and other life stressors such as criminal legal matters, eviction/loss of home, and recent or impending crises, however such circumstances were also common in people with mental health conditions.
- **To address the full range of contributing factors to suicide, comprehensive suicide prevention activities are needed.**
    - Such strategies include both upstream prevention to prevent risk from occurring in the first place as well as more downstream activities responsive to the needs of people at increased risk and to prevent re-attempts.
    - The CDC's technical package to prevent suicide provides information about evidence-based strategies, as well as information about the need for a broad, comprehensive approach to preventing suicide.

25. For some states, the reported percentage increase in the suicide rate is quite large. Is this due simply to fluctuations in small numbers of suicides?

The percentages represent increases in rates between the first three-year reporting period (1999-2001) and the last three-year reporting period (2014-2016). By aggregating the data into three-year periods, small suicide counts were avoided. The table below provides the beginning and ending suicide counts and rates for the ten states showing the largest percentage rate increases.

No suicide count appearing in the table below is less than 200, and some counts range into the thousands. Even after recognizing the growth in state populations and any shifts in their age profiles, changes such as those shown would not typically be expected due to random fluctuations alone.

State	Reporting Period	Average Population *	Total Suicides	Annual Rate †	Percentage Increase	Rank
ND	1999-2001	0.56 M	220	13.3	57.6 %	1
	2014-2016	0.65 M	401	20.9		
VT	1999-2001	0.53 M	212	13.2	48.6 %	2
	2014-2016	0.56 M	345	19.7		
NH	1999-2001	1.08 M	435	13.5	48.3 %	3
	2014-2016	1.20 M	719	20.0		
UT	1999-2001	1.84 M	898	17.2	46.5 %	4
	2014-2016	2.48 M	1,809	25.2		

KS	1999-2001	2.31 M	917	13.3	45.0 %	5
	2014-2016	2.51 M	1,446	19.4		
SD	1999-2001	0.65 M	303	15.7	44.5 %	6
	2014-2016	0.74 M	477	22.6		
ID	1999-2001	1.10 M	558	17.3	43.2 %	7
	2014-2016	1.42 M	1,030	24.7		
MN	1999-2001	4.25 M	1,357	10.7	40.6 %	8
	2014-2016	4.77 M	2,161	15.0		
WY	1999-2001	0.43 M	264	20.7	39.0 %	9
	2014-2016	0.51 M	421	28.8		
SC	1999-2001	3.47 M	1,328	12.8	38.3 %	10
	2014-2016	4.29 M	2,310	17.7		

* Average population ≥ 10 years old during reporting period.
† Annual age-adjusted rate per 100,000 population ≥ 10 years old.

26. What is known about which groups are experiencing increases?

The current study found that rates of suicide are increasing, overall, and for males and females. Rates among females increased significantly in 43 states and rates among males increased significantly in 34 states.

- In general, suicide rates in the U.S. have increased by nearly 30% since 1999.
    i. Increases were observed for both women and men in all age groups under 75.
- Certain groups have had particularly high greatest increases since 1999, including:
    i. Working-age adults 35-64 yrs
    ii. Non-Hispanic whites, and non-Hispanic American Indians / Alaska Natives and
    iii. People living in rural areas.
    iv. Rates have increased for males and female however the rate for males is consistently 3-5 times higher than the rate for females

27. How do people with and without mental health conditions differ with respect to suicide?

People with and without mental health conditions had similarities and differences

- While all decedents were predominately male (76.8%) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely male (83.6% vs. 68.8%;) and racial/ethnic minorities (OR range: 1.2-2.0).
- Suicide decedents without known mental health conditions also had significantly greater odds of perpetrating homicide-suicide (adjusted odds ratio aOR = 2.9, 95% CI = 2.2-3.8). Although this represents a small percentage of suicides in both groups.
- While firearms were the most common method of suicide used overall (48.5%) and for both groups, decedents without known mental health conditions were more likely to die by firearm (55.3% vs. 40.6%) and less likely to die by hanging/strangulation/suffocation (26.9% vs 31.3%) or poisoning (10.4% vs 19.8%) than those with known mental health conditions. (These differences remained significant in the adjusted models).

- Among decedents with toxicology results, decedents without known mental health conditions were less likely to test positive for any substance overall (aOR=0.8, 95% CI=0.7-0.8), such as opioids (aOR=.90 95% CI=0.81-.99) but more likely to test positive for alcohol (aOR=1.2, 95% CI=1.1-1.3).
- People without known mental health conditions were less likely to have substance abuse problems (aOR=0.7, 95% CI=0.7-0.8).
- Two-thirds of those with known mental health conditions had a history of mental health or substance abuse treatment (67.2%) and just over half (54.0%) were in current treatment.
- Decedents without, versus those with, known mental health conditions, had significantly greater likelihood of any relationship problem/loss (45.1% vs. 39.6%), specifically intimate partner problems (30.2% vs. 24.1%), arguments/conflicts (17.5% vs. 13.6%), and recently perpetrating interpersonal violence (3.0% vs. 1.4%). They also were more likely to have experienced any life stressors (50.5% vs 47.2%), such as criminal-legal problems (10.7% vs. 6.2%), or eviction/loss of home (4.3% vs. 3.4%) and were more likely to have had a crisis within the preceding or upcoming two weeks (32.9% vs. 26.0%). All of these differences remained significant in the adjusted models.
- Among all people with crises, intimate partner problems were the most common types and did not differ by mental health group status.
- Physical health problems (23.2% and 21.4%) and job/financial problems (15.6% and 16.8%) were commonly experienced by both groups (with and without mental health conditions, respectively)
- Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR=0.5, 95% CI=0.4-0.5), but among those who were recently released (5.1%), they were significantly more likely to be released from a correctional facility (25.7% vs. 8.7%), hospital (43.7% vs. 33.0%), or other facility (e.g., alcohol/substance treatment) (aOR=2.5 95% CI=1.8-3.3), than those with a known mental health conditions. Among decedents with known mental health conditions who were recently released from an institution (10.2%), 46.7% of this group were released from psychiatric facilities.
- Decedents without known mental health conditions, compared to those with mental health conditions, were significantly less likely to have a history of suicidal ideation (23.0% vs. 40.8%) and prior suicide attempts (10.3% vs. 29.4%). More than one in five people in both groups disclosed suicide intent (22.4% vs. 24.5%).

28. Why did Nevada not see an increase in suicide rates?

While Nevada's suicide rate did not increase, it remained consistently high across the study period.

29. Why did this study focus on those aged 10 and older?

Suicide rates were analyzed for people aged ≥10 years only, because determining suicidal intent in younger children can be difficult.

a. Suicide is defined as self-directed injurious behavior with an intent to die as a result of the behavior, and youth under the age of 10 may not fully understand the implications of their actions. (CDC web site)

30. How was "crisis" defined in this study?

For this study, a "crisis" was a current/acute event that occurred within the 2 weeks of a suicide. Crises are indicated in an NVDRS source report to have contributed to the suicide. A crisis can precede the death (e.g., had a bad argument the day before the incident, divorce papers served that day, or victim laid off the week before) or be an impending event (e.g., house was to be foreclosed on the day after

the incident or court date for a criminal offense three days after the suicide). Crises are interpreted from the eyes of the victim. This is particularly relevant for young victims whose crises, such as a bad grade or a dispute with parents over a curfew, may appear to others as relatively minor.

31. How did you define a mental health condition?

The National Violent Death Reporting System (NVDRS) defines a mental health condition as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (9), with the exception of alcohol and other substance use problems, which are captured separately in the system.

a. Data on mental health conditions are abstracted from the investigative reports included within NVDRS and that are associated with each suicide.
b. Investigative reports are those filed by law enforcement and coroners/medical examiners which reflect information provided by family and friends.
c. Information obtained from these reports is dependent upon the extent of informant knowledge that may impact data completeness and accuracy. Some decedents might have mental health conditions that were not diagnosed or reported. The high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

32. Are the people without mental health conditions just people who haven't been diagnosed with a mental health conditions?

It is possible that the people without mental health conditions in this study had a diagnosable mental health condition but had not been diagnosed, or that their mental health conditions was unknown to informants who provided circumstantial information to law enforcement. Studies including more in-depth interviews with next-of-kin often cite greater attributions to mental disorders, however many methodological variations across studies exist. It is likely that some people without known mental health conditions in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

33. Are suicides by people without mental health conditions considered impulsive?

Suicide decedents who do not have mental health conditions should not necessarily be considered impulsive.

- As this study demonstrates, there are many reasons, beyond mental health conditions alone, why people take their own lives.
- 54% of the study sample did not have a known mental health condition, but people in this group still experienced challenges in their lives that contributed to their suicide.
- They may have been experiencing these challenges for an extended period of time and may have had suicidal thoughts leading up to their suicide, which may indicate that the suicide was not impulsive
    - 35% of those without mental health conditions left a suicide note
    - 23% were known to have a history of suicidal ideation
    - 22% had disclosed suicidal intent to another person
    - 10% had previously attempted suicide

34. How many suicides are considered impulsive?

- *A **previous case-control study of survivors of nearly lethal suicide attempts*** indicates that about 24% of this group acted impulsively on their suicidal thoughts
    - i.e., less than 5 minutes passed between their initial thought of suicide and their nearly lethal suicide attempt
    - **76% of attempt survivors did not meet this definition of impulsivity with respect to their suicide attempt.**

35. Is a trigger usually identified, even if that trigger may seem trivial to us? Also, is there data on the effectiveness of resiliency training in preventing suicide?

Triggering events can be difficult to identify. We found that 29% of suicide decedents had experienced a crisis (intimate partner problem, health problem, legal problem), in the past or upcoming two weeks. These crises were seen as contributing to their suicide. That said, it is important to acknowledge that contributing crises can differ across people depending on individual reactions but also family, friend, employer, and community supports.

Programs like the Good Behavior Game (page 32), and Youth Aware of Mental Health program (p32), which are referenced in our technical package and are designed to build coping and problem-solving skills, have shown positive impacts on suicide ideation and/or behavior, however, a key point in our technical package and the conclusion we mean to draw in our MMWR is a comprehensive public health approach to suicide is important. Ideally suicide prevention activities will be incorporated at the individual, relationship, community, and societal levels to have a real impact. The CDC Foundation is currently helping to raise money for us to test this concept in Colorado which consistently has one of the highest rates of suicide in the country. The US Air Force Suicide Prevention Program is the best example of a comprehensive approach that worked (while it was being fully implemented)—they saw reductions in suicide rates of 33% and reductions in related outcomes as well.

36. Why does this study find such a low rate of mental health conditions compared to psych autopsy studies?

Psychological autopsy studies that utilize in-depth interviewing of surviving friends/family and often include record reviews typically show that a larger proportion of suicide decedents have a mental health diagnosis or a substance use disorder. However, variations in the methodology of psychological autopsy studies and the current study may impact the prevalence of mental health conditions identified. It is likely that some people without known mental health conditions in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. NVDRS measures problematic substance use separately from mental health conditions and this report provides an estimate of problematic substance use among those with and without mental health conditions.

The high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

37. Why did you only look at suicide circumstances in 27 states?

a. In 2015, the National Violent Death Reporting System collected data from 27 states. The data collected from these states were used for the analysis. More current data is not yet available.

b. In 2016, NVDRS collected data from 40 states, D.C. and Puerto Rico however data are not yet available.
c. The FY 2018 omnibus appropriation bill provided funding and Congressional direction to expand the NVDRS program to all 50 states and the District of Columbia. CDC is actively working toward that goal.

38. What are some of the limitations to this study?

There are three limitations to the study:

- First, **in the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward), or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward).**
- Second, **NVDRS is not yet nationally representative**; the 27 states included in this study represent 49.6% of the U.S. population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml).
- Third, **abstractors of NVDRS data are limited to information contained in investigative reports.** Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often cite greater attributions to mental disorders, however many methodological variations across studies exist. It is likely that some people without known mental health conditions in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.
- **We know that suicides are underreported.** It is possible that some suicides were coded as unintentional or deaths of undetermined intent. It is unclear how that could impact estimates of trends or conclusions about circumstances.

The National Violent Death Reporting System

39. What is the National Violent Death Reporting System?

- The **National Violent Death Reporting System (NVDRS) is a data system that provides states and communities with a clearer understanding of violent deaths.** NVDRS data can be used to guide local decisions about efforts to prevent violence and track progress over time. NVDRS is the only state-based surveillance (reporting) system that pools data on violent deaths from multiple sources into a usable, anonymous database. These sources include state and local medical examiner, coroner, law enforcement, toxicology, and vital statistics records. Pooling these data can provide CDC with a detailed, comprehensive picture of how and why violent deaths occur.
- **NVDRS includes over 600 unique data elements that provide valuable context about violent deaths such as**
  - Relationship problems; mental health conditions and treatment; toxicology results; and life stressors
    - Including recent problems with a job, finances, or physical health problems.

- Extensive information about the incidents, such as weapons used, characteristics of suspects, and locations where they occurred are included. Such data are far more comprehensive than what is available elsewhere.

- **NVDRS can help identify populations particularly affected by fatal violence**. The system not only provides details on specific manner of violent death, but also identifies common factors that span multiple types of violence.
- The NVDRS FAQ page has more details: https://www.cdc.gov/violenceprevention/nvdrs/faqs.html

40. How does using the National Violent Death Reporting System help to make the statistics more complete?

Although limited to the 27 states participating in NVDRS during the time period of the study, **data from NVDRS provide the only detailed information available on the circumstances surrounding these deaths**, therefore taking the findings beyond reporting numbers and rates and providing unique information on the context in which people die from suicide.

41. Is the National Violent Death Reporting System expanding to 50 states?

We are happy to announce that **beginning in FY18, we are able to make funding available to all 50 states for the implementation of the NVDRS.**

Currently, 40 states, Washington, DC and Puerto Rico are funded by NVDRS.

Expanding NVDRS to 50 states allows us to meet one of the national goals set forth for Healthy People 2020 (IVP-43).

Warning signs of suicide and what to do if you know someone at risk

42. A lot of the problems mentioned as contributing to suicide in this study seem very common, how can someone tell who's at risk?

Many people think that suicide is an inexplicable act, when, in reality, many known risk factors exist.

These include:

- History of previous suicide attempts
- Family history of suicide
- History of child maltreatment
- History of depression or other mental illness
- Alcohol or drug abuse
- Feelings of hopelessness or isolation
- Impulsive or aggressive tendencies
- Stressful life event or loss
- Easy access to lethal methods
- Exposure to the suicidal behavior of others
- Isolation, lack of social connectedness

Researchers agree that suicidal behavior results from an interaction of factors and is rarely due to a single cause.

43. Is suicide genetic?

Research suggests that suicide can run in families. A famous example is the multiple deaths by suicide in the family of American novelist Ernest Hemingway. Both genetics (nature) and environment (nurture) can impact suicide risk; however, there are many strategies to prevent suicide. Suicide is never inevitable.

- A new field of study called epigenetics looks at the interaction of nurture and nature to help us understand risk of suicide.

44. What are the warning signs for suicide?

The warning signs for suicide are:

- Expressing hopelessness
- Increased anger or rage
- Extreme mood swings
- Sleeping too little or too much
- Making plans for suicide
- Talking and/or posting about suicide
- Feeling unbearable pain
- Increased anxiety
- Securing lethal means
- Increased substance use
- Feeling like a burden
- Isolation

45. What should someone do if they believe someone may be suicidal?

- **Ask** the question, "Are you thinking about suicide?" Asking the question won't make someone suicidal, and instead, may relieve or reduce the feeling.
- If the person says yes, **keep** them safe. Find out if they have a suicide plan. Remove any lethal means in the environment, if possible, and do not leave the person alone.
- **Be there** and show concern. Don't act surprised or dismiss their feelings. Take the person seriously, and do not assume they are joking.
- **Help them connect** to resources, for example, by calling the National Suicide Prevention Lifeline (1-800-273-TALK (8255)) or by connecting the person to someone in the community who can help, e.g. emergency department, counselor, pastor.
- **Follow up -** After the person is safe, follow up in the days ahead with a phone call, ask them how they are doing. See if there is anything else that you can do.

You can learn more about these steps to help by going to www.bethe1to.com.

46. Where can people go for help?

No matter what problems people deal with, we want to help them find a reason to keep living. By calling 1-800-273-TALK (8255) people will be connected to a skilled, trained counselor at a crisis center in their area, anytime 24/7. There are many success stories and stories of hope where people in need have reached out to others or family or friends have intervened to get people help. They got the support they needed and were able to get through a crisis and go on to live productive and fulfilling lives.

Suicide among Youth

47. Today's Quick Stat shows rates of suicide and homicide going up among youth. How does this align with rates found in the VS?

The Vital Signs report did not examine suicide rate increases by age group or homicide at all, but we know that suicide is a problem across the lifespan. In fact, suicide rates increase with age up to age 54.

Nationally, we have seen that suicide rates are increasing across all age groups younger than age 75. For example, middle aged adults have the largest number of suicides and have seen particularly high increases in rates. Suicide prevention strategies are needed across the lifespan. States and communities can adopt prevention strategies based on the best available evidence such as those found in the CDC's technical package to prioritize populations with the greatest burden based on both rates and numbers of suicide.

	10-24	25-44	**45-64**	65+
1999 (rate per 100,000)	7.04	13.57	**13.22**	15.80
2016 rate	9.21	16.91	**19.22**	16.66
Percentage increase	31	25	**45**	5
1999 suicide counts	4143	11572	**7977**	5489
2016 suicide counts	6159	14396	**16196**	8204
total counts 1999-2016	86118	221469	**232108**	109915

48. A report came out recently about suicidal thoughts and behavior in youth in Utah. Between these results and other recent findings, should we be focused primarily on youth suicide prevention?

Suicide at any age is troubling and a cause for concern. Today's Vital Signs did not look at suicide rate increases by age group; however, in order to bring rates down, we must apply effective suicide prevention strategies to those population groups at greatest risk and with the greatest burden (based on rates and numbers of suicide).

Note: The Utah study results show similar suicide attempt rates to the National YRBS and while the percentage of people with ideation is greater than the national percentage, in Utah, rates of suicide ideation were defined by any serious thoughts of suicide in the past 12 months or any suicide planning. National rates do not combine these questions, which may explain the difference in state and national prevalence.

	Utah study	National YRBS
Suicide ideation	20%*	17.7%
Suicide attempts	8.2%	8.6%

*The Utah study included students in grades 6, 8,10, and 12 whereas National YRBS is for students in 9-12th grades. Also, the Utah study combined two questions (any serious thoughts of suicide or suicide plans). The National YRBS estimate shown in for thoughts of suicide only.

49. Is the Netflix series, 13 Reasons Why, making youth suicide rates increase?

While we have seen youth suicide rates increase over the past several years, it is difficult to attribute the increases to any one factor. However, we do know that suicide contagion is a real phenomenon, and that when vulnerable youth are exposed to suicidal thoughts or behaviors, their risk for suicide can increase. The media, including the entertainment industry, can help prevent the risk of suicide contagion by safely reporting on suicide and referring to recommendations available at www.reportingonsuicide.org. In response to season one of 13RW and in preparation for Season 2, SAVE (Suicide Awareness Voices of Education) convened a group of experts in suicide prevention, mental and physical health, and education to develop tools to help encourage positive responses to the 13 Reasons Why series.

- The group developed a toolkit providing practical guidance and reliable resources for parents, educators, clinicians, youth and media related to the content of the series (suicide, school violence, sexual assault, bullying, substance abuse, etc.). The toolkit can help encourage conversations, identify those at risk and prevent unexpected tragedies. https://www.13reasonswhytoolkit.org/

50. Recently a study came out about high levels of loneliness among youth. Is that why youth suicide rates are going up?

Loneliness or feeling a lack of connectedness to others is a risk factor for suicide among people of all ages. However, for any given individual, suicide is typically not caused by any one thing. Today's Vital Signs reports on the *multiple* contributing factors to suicide including relationship problems, substance misuse, and health, job/financial, and criminal legal problems. To help communities make use of the best available evidence for suicide prevention, CDC released a suicide prevention technical package. Many of the strategies in the technical package are likely to help people feel connected and less lonely. This is an important part of a comprehensive suicide prevention strategy.

51. Recently a study came out about increasing rates of depression, especially among youth. Is that why suicide rates are going up?

On a population level, increases in depression can impact suicide rates, especially untreated depression, however, for any given individual, suicide is typically not caused by one thing. It is unclear how much these trends in depression are influencing the increases in suicide rates. Today's Vital Signs reports on the multiple contributing factors to suicide including relationship problems, substance misuse, and health, job/financial, and criminal legal problems. A comprehensive approach to suicide prevention must address mental health conditions like depression as well as these other factors.

Suicide among Veterans

52. Do you have any information on suicide among Veterans and Military service members?

While we did not describe Veteran suicides in this study, here are some key epidemiologic findings from other reports published by the Departments of Veterans Affairs and Defense, as well as the CDC .

CDC and its partners are currently doing more research to understand the extent to which the general rise in suicide rates can be attributed to the rise in suicide rates among Veterans.

Veterans:

- **Veterans accounted for 18 percent of adult suicides but constituted only 8.5 percent of the U.S. adult population (ages 18+).**

- An average of **20 Veterans died by suicide each day**; roughly **14 of these are not using VHA services**.
- The overall **burden of Veteran suicide is mostly among Veterans of middle to older adult ages**.
    - An estimated 65% of Veteran suicides occurred among Veterans ages 50 years an older
- **Rates dramatically increased from 12/100,000 in 2005 to 110/100,000 in 2014** among young Veterans aged 18-24 years who were using VHA services and were in Operations Enduring Freedom, Iraqi Freedom, or New dawn
- Suicides among young Veterans aged 18-35 years are highly concentrated in a small proportion of counties.
    - Within 17 NVDRS states, an estimated 33% of suicides among Veterans aged 18-35 years occurred in just 3% of U.S. counties and 69% occurred in 13% of U.S. counties. Many of these high burden counties do not have easy access to VHA facilities.
- Accounting for age and sex, risk for suicide was 21 percent higher among Veterans versus civilians.
- Accounting for age, risk for suicide was 2.4 times higher among female Veterans versus female civilians

Active duty:

- Suicide rates have doubled from 12.5 per 100,000 in 2005 to 30 deaths per 100,000 in 2012. Steady declines in recent years have been observed (although this could be because more service members were recently discharged and therefore their suicides would be reflected in the Veteran population)
- Since 2001-2014, 51% of suicide decedents were Army service members; 18% were Air Force service members; 17% were Navy service members; 14% were Marines
- Key epidemiological findings include:
    - 94% were male
    - 72% were of white race
    - 87% were of non-Hispanic ethnicity
    - 83% were under the age of 35 years
    - 88% were in the enlisted ranks of E1-E9
    - 72% only had a high school graduate level of education (or less)
    - 52% were married
    - 68% of suicides were the result of firearm injuries
    - 54% had a history of deployment

53. Do you think the rate increases in suicide across the U.S. is the result of increases in Veteran suicides?

For this study, we were unable to explore the reasons why we observed these state increases. Therefore, we are unable to determine the extent to which the broad increase in suicide rates across the states is the result of increases in the Veteran suicide rate. This question needs further exploration.

54. Is CDC engaged in preventing suicides among Military service members and Veterans?

CDC has partnered with the Departments of Veterans Affairs and Defense on numerous innovative suicide prevention projects to help address and prevent suicide among active duty service members and Veterans.

- The innovations span across public health service. Such efforts are focused to:
    - Improve surveillance of suicide
    - Increase understanding of the antecedents of suicide and potential factors that might protect against risk of suicide
    - Improve early identification of suicide risk and rapid response to those in need of services, and evaluate key population-level suicide prevention policies and strategies being implemented across states and at military installations.

Opioids and Suicide

55. How are suicide, opioid misuse, and Adverse Childhood Experiences related?

We know that adults who experienced Adverse Childhood Experiences, or ACEs, are at risk for both suicide and substance misuse. Additionally, it is important to note that children whose parents are dealing with substance use disorder or have overdosed are experiencing ACEs, as are children whose parents attempt or die from suicide. So addressing trauma and preventing ACEs can be important to prevention of suicide and opioid misuse as well.

56. Why are opioid overdoses increasing?

Drug overdoses killed 63,632 Americans in 2016. Opioids—prescription and illicit—are the main driver of drug overdose deaths. Nearly two-thirds of these deaths (66%) involved a prescription or illicit opioid. Overdose deaths increased in all categories of drugs examined for men and women, people ages 15 and older, all races and ethnicities, and across all levels of urbanization.

The rise in opioid overdose deaths can be outlined in three distinct waves:

- The first wave began with increased prescribing of opioids in the 1990s , with overdose deaths involving prescription opioids (natural and semi-synthetic opioids and methadone) increasing since at least 1999.
- The second wave began in 2010, with rapid increases in overdose deaths involving heroin.
- The third wave began in 2013, with significant increases in overdose deaths involving synthetic opioids – particularly those involving illicitly-manufactured fentanyl (IMF). The IMF market continues to change, and IMF can be found in combination with heroin, counterfeit pills, and cocaine.
- Recent CDC data (Seth P, Scholl L, Rudd RA, Bacon S. Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants — United States, 2015–2016. MMWR Morb Mortal Wkly Rep. ePub: 29 March 2018.) confirms that increases in drug overdose deaths are being driven by continued sharp increases in deaths involving synthetic opioids other than methadone, such as illicitly manufactured fentanyl (IMF).

57. Does prescribing opioids to patients with chronic health conditions increase suicide risk?

Research has shown that chronic health conditions, including painful conditions such as arthritis, migraines, and fibromyalgia, are associated with increased suicide risk. Further, patients receiving opioid therapy for chronic pain are at elevated risk for mental health conditions and suicide attempts. This may reflect an increased likelihood of prescribing opioids by providers to patients with risk factors for suicide, including mental health conditions, chronic pain, and opioid use disorder. Increased opioid availability can also offer greater access to lethal means for suicide.

58. Can the increase in suicides among certain populations be attributed to opioid use, or to chronic pain?

A recent study showed that chronic health conditions are associated with increased suicide risk, particularly when multiple chronic conditions are present (Ahmedani et al., 2017). Opioids can be prescribed for chronic conditions, and patients receiving opioid therapy are at elevated risk of attempting suicide. However, suicide risk might be able to be reduced by improving pain management consistent with prescribing guidelines. For example, in a study of veterans on long-term opioid therapy, approximately 1-2% of patients attempted suicide within 6 months of receiving a prescription. The VA facility engaged in an effort to increase compliance with prescribing guidelines by making more consistent use of drug screening, providing follow-up within 4 weeks for patients initiating new opioid prescriptions, and avoiding co-prescribing of sedatives with opioids. The study found that by providing follow-up as recommended in the guideline, the risk of suicide could be reduced by 5 times (Im et al., 2015). In a second study, researchers found that compliance with the VA/Department of Defense (DOD)

guideline improved patient safety for VA opioid-prescribed patients (Brennan et al 2016). For example, urine drug screening increased significantly, and this was associated with lower risk of suicide among patients.

59. Has the CDC's Guideline for Prescribing Opioids caused people suffering in pain to contemplate or die by suicide?

Chronic pain can result in considerable suffering. Having a chronic pain condition, compared to no physical pain, is associated with a higher likelihood of suicide, suicidal ideation and suicide attempts, and in many cases this association persists even after controlling for co-morbid mental health and/or substance use disorders. This is the finding of a recent meta-analysis of 30 studies that examined the association of physical pain with a range of suicide related outcomes among people with and without pain conditions. (Ref: Calati, R., Artero, S., Courtet, P., & Lopez-Castroman, J. (2016). Framing the impact of physical pain on suicide attempts. A reply to Stubbs. J Psychiatr Res, 72, 102-103. doi:10.1016/j.jpsychires.2015.10.018)

- **Among patients taking opioids, a recent study suggests that the most important factor that predicts transition from suicidal ideation to suicidal attempt is the belief that pain can't be successfully managed (i.e. hopelessness about pain management), rather than factors such as condition or pain severity.**
- A recent study of US veterans prescribed opioid medications for chronic pain management revealed that a very small percent attempted suicide (less than 2%), and that having a mood disorder increased the risk for suicide attempt. Importantly, use of guideline-recommended practices, including use of urine drug testing, greater-follow-up, and lower co-prescription of sedatives was associated with a lower risk of suicide attempts.

Additional research would tell us more about the associations among chronic pain, opioid use, and suicide, and inform prevention efforts. The available evidence highlights the importance of urine drug testing and avoiding co-prescribing of benzodiazepines, whenever possible, and providers remaining alert to signs of anxiety and depression, using validated instruments to assess for mental health conditions, re-evaluating patients with depression or mental health conditions more frequently than every 3 months, considering use of tricyclic or SNRI antidepressants for analgesic as well as antidepressant effects, and considering behavioral health specialist consultation for any patient with a history of suicide attempt or mental health disorder, as recommended in the CDC Guideline.

60. Why doesn't CDC think chronic pain is important? Why is the prescription drug overdose epidemic the focus?

Chronic pain is a public health concern in the United States. Patients with chronic pain deserve safe and effective pain management.

- Opioids can help manage some types of pain but also have serious risks of addiction and overdose.
- While evidence supports short-term effectiveness of opioids, there is insufficient evidence that opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.

- Primary care providers are concerned about opioid pain medication misuse, are worried about patient addiction, and want more training in prescribing opioids.

CDC's role is to tackle the biggest health problems causing death and disability for Americans, putting science and advanced technology into action to prevent disease and promote healthy and safe behaviors, communities and environment.

CDC recently played a leading role in getting public health goals pertaining to chronic pain included in Healthy People 2020, and facilitated the inclusion of questions about chronic pain in the 2016-17 National Health Interview Survey.

CDC scientific experts also provided review and input regarding the overall National Pain Strategy (NPS) led by HHS. The NPS outlines a coordinated plan for reducing the burden of chronic pain on the American public. It includes key recommendations in areas including population research, prevention and care, disparities, service delivery and payment, professional education and training, and public education and training. The strategy calls for:

- "Developing methods and metrics to monitor and improve the prevention and management of pain.
- Supporting the development of a system of patient-centered integrated pain management practices based on a biopsychosocial model of care that enables providers and patients to access the full spectrum of pain treatment options.
- Taking steps to reduce barriers to pain care and improve the quality of pain care for vulnerable, stigmatized and underserved populations.
- Increasing public awareness of pain, increasing patient knowledge of treatment options and risks, and helping to develop a better informed health care workforce with regard to pain management."

Drug overdose one of the few problems getting worse in US – affecting all ages, races, communities. The opioid overdose crisis is being fueled by both prescription opioids and illicit drugs, like heroin and illicitly-manufactured fentanyl. CDC plays an important role in understanding and addressing the causes of the opioid overdose epidemic.

- Opioids (including prescription opioids, heroin, and fentanyl) killed more than 42,000 people in 2016, more than any year on record.
- 40% of all opioid overdose deaths involve a prescription opioid.
- The best ways to prevent opioid overdose deaths are to improve opioid prescribing, reduce exposure to opioids, prevent misuse, and treat opioid use disorder.

Managing chronic pain is important to the health and well-being of all Americans, and preventing, assessing, and treating chronic pain can be a challenge. Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse opioids, develop opioid use disorder, or overdose from these drugs. The CDC guideline provides recommendations to help determine when to initiate and continue opioid prescribing for pain outside of active cancer treatment, palliative care, and end-of-life care to ensure patients have access to safe and effective chronic pain treatment. CDC aims to save lives and prevent prescription opioid overdoses by equipping providers with the knowledge, tools, and guidance they need.

Adverse Childhood Experiences and Suicide

61. What are ACEs

Adverse Childhood Experiences (ACEs) is the term given to describe types of abuse, neglect, and other household challenges that occur to individuals under the age of 18. The landmark Kaiser ACE Study examined the relationships between these experiences during childhood and reduced health and well-being later in life. The term encompass 10 experiences listed in the original ACE questionnaire.

A. Abuse
   1. Emotional abuse
   2. Physical abuse
   3. Sexual abuse

B. Neglect
   4. Emotional neglect
   5. Physical neglect

C. Household challenges
   6. Substance abuse (of household member)
   7. Mental illness (of household member)
   8. Mother treated violently
   9. Parental separation or divorce
   10. Incarcerated household member

62. What is an ACE score?

The ACE score, a total sum of the different categories of ACEs reported by people, is used to assess cumulative childhood stress. The score ranges from 0 (unexposed) to 10 (exposed to all categories). Study findings repeatedly reveal a graded dose-response relationship between ACEs and negative health and well-being outcomes across the life course.

63. What is CDC doing to prevent ACEs?

Safe, stable, nurturing environments for all children play a large role in preventing ACEs by creating a context and atmosphere that allows families to share quality time together, to discuss and resolve conflicts, and to provide emotional support to one another. CDC's technical package for preventing the different forms of violence impacting children and families can help states and communities prioritize prevention activities based on the best available evidence. These strategies range from a focus on individuals, families, and relationships, to broader community and societal change. For example, the child abuse and neglect technical package includes changing social norms to support parents and positive parenting, enhancing parenting skills to promote health child development, Strengthening economic supports for families, and providing quality care and education early in life, and intervening to lessen harms and prevent future risk.

64. How are ACEs and suicide related?

Research suggests that the greater the number of ACEs, the greater the risk of suicide attempts. ACEs have been associated with increased risk for a variety of outcomes that could contribute to stress and

risk for suicide, including unhealthy coping; physical, mental health, and behavioral health disorders; and diminished life opportunities such as reduced education, employment, and income.

Suicide Prevention

65. Did the study provide recommendations for prevention?

Comprehensive suicide prevention activities both upstream (before suicide risk begins) and downstream (after people have been identified as at-risk, or have attempted suicide) are needed to address the full range of factors contributing to suicide.

- For example, among people with mental health conditions, the study identified a need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to providers in underserved areas is needed, as is expansion of healthcare systems that integrate physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions.
- In addition to strategies addressing mental health conditions, the study identified the need for attention to the broader range of circumstances contributing to suicide, including relationship, substance use, physical health, job, financial, and legal problems.

Taken, together a comprehensive approach to suicide includes the following strategies:

- Identifying and supporting people at risk of suicide.
- Teaching coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments, including safely storing medications and firearms to reduce access among people at risk.
- Connecting people to others in their community so they don't feel alone.
- Connecting people at risk to effective and coordinated mental and physical healthcare.
- Expanding options for temporary assistance for those struggling to make ends meet.
- Preventing future risk of suicide among those who have lost a loved one to suicide

Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices*, available at: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf to better understand their suicide problem, prioritize evidence-based comprehensive suicide prevention, and save lives.

66. What can be done to prevent suicide?

Suicide is preventable.

CDC released a technical package of policies, programs, and practices to prevent suicide to help communities focus on a core set of strategies that have the best available evidence and greatest prevention potential.

The technical package includes examples of programs that local implementers might tailor to fit the needs of their community. The technical package **includes 7 strategies designed to work together to achieve the greatest impact possible**.

i. Strengthen economic supports
ii. Strengthen access and delivery of suicide care
iii. Create protective environments
iv. Promote connectedness
v. Teach coping and problem-solving skills
vi. Identify and support people at risk
vii. Lessen harms and prevent future risk

For example, an evidenced based suicide prevention program called Sources of Strength was developed with rural and tribal communities in North Dakota to promote connectedness between youth and caring adults. The program works to understand and respond to underlying causes of suicidal behavior and promote protective factors against suicidal behavior before the causes result in adverse outcomes.

Other innovative prevention strategies, such as telebehavioral health (telephone, video and web-based technologies), are a promising option to increase access to health care and mental health care in rural communities. However, rural communities often have limited access to the internet suggesting a need to increase broadband access and to identify other ways to deliver promising prevention supports.

Everyone can play a role in suicide prevention.

- Physicians have an important role to play in recognizing and appropriately treating mental health conditions.
- Other professionals who work with vulnerable populations (e.g. parole officers, teachers, etc.) play an important role in identifying and referring at-risk individuals.
- Employers can play a role too.
    - Employee assistance programs can work to reduce stigma about seeking help and improving access to care.

There are also recommendations for the media regarding how to report on suicide to raise awareness without increasing the risk of additional suicides among vulnerable populations. We know that risk can increase when the media provides details about the methods used, dramatic/graphic headlines, or glamorize a death (see reportingonsuicide.org).

67. What is a technical package?

- A technical package is **a collection of strategies that represent the best available evidence to prevent or reduce public health problems like violence**. They can help improve the health and well-being of communities.

CDC's suicide prevention technical package is intended as a resource to guide decision-making in communities and states.

- CDC expert scientists reviewed the literature and summarized the best-available evidence in the technical package. The package has been reviewed by grantees/funded partners, federal partners, and other audiences.
- The technical package highlights seven strategies to prevent suicide.
- This technical package describes programs, practices, and policies along with the evidence of their impact on suicide or risk and protective factors for suicide.
- The strategies are presented in order from those with the greatest potential to produce broad public health impact on suicide followed by those with potential to impact subsets of the population (e.g., persons who have already made a suicide attempt).

68. If suicide rates are increasing, does that mean the evidenced-based strategies that have been identified are not working?

The evidence tells us that there are strategies that work.

- These strategies and approaches do not work if they aren't properly implemented or expanded to reach larger audiences.
- There are many reasons why effective programs are not implemented and expanded, but a lack of funding for suicide prevention has been identified as a contributing factor.

The most effective strategies are comprehensive and use a public health approach as opposed to focusing exclusively on mental health conditions, to impact a broader audience. There is also the issue of stigma around suicide and mental health care, which discourages people at risk for self-harm from seeking help. Suicide is preventable, but we need sufficient investment and a comprehensive public health approach.

69. Where can people go to get more information about suicide prevention?

Visit the CDC Injury Center website at https://www.cdc.gov/violenceprevention/suicide/

70. What partnerships or sectors should be involved in suicide prevention?

- Public health agencies can play an important role in preventing suicide. They can provide leadership and bring critical resources to address the problem. However, the strategies and approaches outlined in CDC's technical package cannot be accomplished by the public health sector alone and require a collective effort across sectors.
- Other sectors vital to prevention efforts include:
    - Education
    - Government (local, state, and federal)
    - Social services
    - Health services
    - Business
    - Labor
    - Justice
    - Housing
    - Media
    - Community organizations (e.g., foundations or faith-based and other organizations)
- Each sector has an important role:
    - Local and state public health agencies and organizations can work to convene partners, lead efforts, track progress, and help evaluate efforts.
    - Education and the public health sector are vital to supporting the development, evaluation, and adoption of effective programs that promote connectedness or that teach coping and problem-solving skills.
    - Business, workplaces, housing, and local and state government entities are in a position to help implement policies and programs that directly address some of the underlying risks and environments that increase the risk for suicide.
    - The healthcare, public health, justice, and social service sectors can work together to identify and support people at-risk of suicide and their families.
    - Across all strategies – community organizations and other non-governmental organizations are vital to prevention.

71. Is it necessary to monitor and evaluate prevention efforts?

- It is important to have data to monitor the extent of the problem so you can see if your prevention efforts are producing the desired impact.
- There are existing data sources for you to consider such as CDC's National Vital Statistics System (NVSS), the National Violent Death Reporting System (NVDRS), the National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP), the Youth Risk Behavior Surveillance System (YRBSS), and the National Survey on Drug Use and Health (NSDUH).
    - If gaps in the data exist, you may want to look for data collected at the local level. YRBSS provides some local data. You may also want to consider data from state and local Child Death Review teams and Suicide Death Review Teams (where available).
- The data you collect can be used to identify and address gaps in surveillance systems as well as plan programs and evaluate the impact of your efforts.

Talking about suicide & suicide contagion

72. Will talking about suicide give people the idea to do it? Could we do more harm than good?

Talking about suicide does not cause suicide to occur.

- In fact, **it can be an excellent prevention tool.**
    - Talking breaks the secrecy that surrounds suicidal behavior and lets people know that help is available.
- **By not talking about suicide, we increase the isolation and despair of individuals thinking about it and perpetuate the stigma associated with suicidal ideation and behavior.**

73. What is meant by "suicide contagion" or "copy-cat" suicide?

These words describe a process by which exposure to suicide or suicidal behavior of one or more persons influences similar behavior by vulnerable individuals. Research has shown that graphic, sensationalized or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion.

74. Do media reports regarding suicide increase the number of copy-cat suicides? What suggestions does CDC have for news media covering suicide issues in their community?

CDC research suggests that stories about suicide can help inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. They can also highlight opportunities to prevent suicide. Media stories about individual deaths by suicide may be newsworthy, but they also have the potential to do harm. Implementation of recommendations for media coverage of suicide has been shown to decrease suicide rates. For more information about these recommendations and tips for covering suicide visit Reporting on Suicide: Recommendations for the Media: https://www.afsp.org/news-events/for-the-media/reporting-on-suicide

75. What suicide story angles should reporters consider?

- Trends in suicide rates accompanied by prevention strategies
- Recent advances in prevention strategies
- Individual stories of how prevention was life-saving

- Stories of people who overcame desperate circumstances without attempting suicide
- Myths about suicide
- Warning signs of suicide
- Actions that individuals or families can take to prevent suicide by others
- Actions that communities can take to support connections among people that help to reduce risk

What role do the economy and social media play in increasing suicide rates?

76. What role does the economy play in increasing suicide rates?

The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability could have contributed to increases in suicide risk. Past research on the association between business cycles and U.S. suicide indicate that the overall suicide rate rises and falls in connection with the economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.

77. Is social media use to blame for increasing suicide rates?

More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

Select Recent CDC Research

- CDC has released several publications recently.
    - **CDC just released a study on the timing of suicides.**
        - The study examined 122 thousand suicides from the National Violent Death Reporting System in 18 U.S. States from 2003 through 2014.
        - Results: Suicides significantly increased ($p < 0.05$)
            - from March to peak in September before falling, the first week of the month
            - early in the week
            - in the morning, mainly peaking during the afternoon, although suicides in adolescents peaked in the evening and in those 65 years and older peaked in the morning.
            - differences were observed by sex, age, and race/ethnicity.
        - Results from research on suicide timing can potentially help inform planning for prevention activities before periods of relatively high suicide. To help communities make use of the best available evidence for suicide prevention, CDC released a suicide prevention technical package. The technical package describes the importance of a comprehensive approach, which includes Identifying and supporting people at increased suicide risk and upstream approaches that reduce a range of known risk factors.

- Tian, N., Zack, M., Fowler, K. A., & Hesdorffer, D. C. (2018). The Timing of Suicide in 18 United State States from 2003-2014. *Archives of Suicide Research*, (just-accepted), 1-21.

  - In mid-May, **the National Center for Health Statistics released a study describing county-level trends in U.S. suicide rates from 2005-2015.**
    - This study, published in the American Journal of Preventive Medicine, documents that county-level suicide rates increased by more than 10% from 2005 to 2015 in 99% of counties in the U.S.
    - 87% of counties showed an increase of greater than 20%
    - States and communities can use these data in combination with the results from the present study to obtain more granular level detail about suicide rates within their states and to help focus prevention efforts.

  - Late last year, we released **a JAMA article analyzing the number of youth visiting emergency rooms with nonfatal, self-inflicted injuries.**
    - We found that self-inflicted injuries are one of the strongest risk factors for suicide. Our research found that emergency room visits for self-inflicted injuries among young females increased significantly in recent years (2001-2015)-particularly among girls 10-14.
    - And since the risk leads to a potentially fatal outcome, monitoring trends in Self-inflicted injuries is critical to preventing suicide in young people.
      - Mercado MC, Holland K, Leemis RW, Stone DM, Wang J. Trends in Emergency Department Visits for Nonfatal Self-inflicted Injuries Among Youth Aged 10 to 24 Years in the United States, 2001-2015. *JAMA*.2017;318(19):1931–1933. doi:10.1001/jama.2017.13317

  - In February of this year, CDC released **a Morbidity and Mortality Weekly Report (MMWR) summarizing 2014 data from the 18 states participating in the National Violent Death Reporting System (NVDRS) at that time.**
    - Violent deaths due to self-inflicted injury or interpersonal violence disproportionately affected people aged 45-64 men, and American Indian/Alaska Natives.
    - There were several primary precipitating factors for both homicides and suicides that stood out including: intimate partner problems, interpersonal conflicts, mental health and substance abuse conditions, and recent crises
    - NVDRS is currently in 40 states, the District of Columbia, and Puerto Rico, with goals to expand nationally.
    - Developing and expanding NVDRS is crucial to public health efforts at the federal, state, and local levels, in order to identify information like precipitating factors and also to target prevention efforts.
      - Fowler KA, Jack SP, Lyons BH, Betz CJ, Petrosky E. Surveillance for Violent Deaths — National Violent Death Reporting System, 18 States, 2014. MMWR Surveill Summ 2018;67(No. SS-2):1–36.

  - As part of our commitment to suicide prevention in vulnerable populations, in March of this year, CDC released another **MMWR, specifically on suicides among American Indian/Alaska Natives.**
    - It showed that the rates of suicide among American Indian/Alaska Natives have been increasing since 2003.

- Analysis of the data from 18 states, showed that AI/AN people who died by suicide were younger and were more likely to live in a non-metropolitan area than non-Hispanic whites who died by suicide.
- The data show a clear need for culturally relevant intervention strategies for this population.
  Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. MMWR Morb Mortal Wkly Rep 2018;67:237–242.

Partner Activities

1. *What is the National Action Alliance for Suicide Prevention?*
   The National Action Alliance, also referred to as the "Action Alliance" is a public-private partnership that works to advance the National Strategy for Suicide Prevention and make suicide prevention a national priority.

2. *What is the National Strategy for Suicide Prevention?*
   This is a report created by the U.S. Surgeon General and the Action Alliance. It emphasizes the role everyone can play in protecting their friends, family, and colleagues from suicide. It has been revised to include a decade of research and other advancements in order to provide guidance for several sectors like schools, businesses, and health systems.

3. *What is Project 2025?*
   Project 2025 is a collaborative initiative developed by American Foundation of Suicide Prevention (AFSP). The goal of Project 2025 is to reduce the annual suicide rate 20 percent by year 2025. AFSP has determined a series of actions and critical areas to help reach the goal, which includes approaches that reach across all demographic and sociological groups.

4. *What is Zero Suicide?*
   This a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention, and is supported by the Substance Abuse and Mental Health Services Administration It requires that health and behavioral health care systems commit to making suicide prevention a core priority and implement processes and strategies that prevent suicide and improve the care of patients at risk for suicide.

Additional Resources

Recommendations for Media about Safe Reporting on Suicide, reportingonsuicde.org

If you or someone you know is thinking about suicide or needs support, help is always available. Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or visit http://suicidepreventionlifeline.org

Preventing Suicide: A Technical Package of Policy, Programs, and Practices: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf.

National Strategy for Suicide Prevention, http://actionallianceforsuicideprevention.org/national-strategy-suicide-prevention-0

Suicide Prevention Resource Center, https://www.sprc.org/

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Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

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Abstract

Introduction: Suicide rates in the United States have risen nearly 30% since 1999, and mental health conditions are one of several factors contributing to suicide. Examining state-level trends in suicide and the multiple circumstances contributing to it can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among persons aged ≥10 years, by state and sex, across six consecutive 3-year periods (1999–2016), were assessed using data from the National Vital Statistics System for 50 states and the District of Columbia. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health conditions.

Results: During 1999–2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases >30%. Rates increased significantly among males and females in 34 and 43 states, respectively. Fifty-four percent of decedents in 27 states in 2015 did not have a known mental health condition. Among decedents with available information, several circumstances were significantly more likely among those without known mental health conditions than among those with mental health conditions, including relationship problems/loss (45.1% versus 39.6%), life stressors (50.5% versus 47.2%), and recent/impending crises (32.9% versus 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states during 1999–2016. Various circumstances contributed to suicides among persons with and without known mental health conditions.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends and family members in the aftermath of a suicide.

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U.S. Department of Health and Human Services
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Introduction

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (*1*). From 1999 to 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (*2,3*). Suicide rates have also increased among persons in all age groups <75 years, with adults aged 45–64 having the largest absolute rate increase (from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (232,108) during the same period (*1,3*). Suicide is the tenth leading cause of death and is one of just three leading causes that are increasing (*1,4*). In addition, rates of emergency department visits for nonfatal self-harm, a main risk factor for suicide, increased 42% from 2001 to 2016 (*1*). Together, suicides and self-harm injuries cost the nation approximately $70 billion per year in direct medical and work loss costs (*1*).

The National Strategy for Suicide Prevention (*5*) calls for a public health approach to suicide prevention with efforts spanning multiple levels (individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is determined by multiple factors. Despite this call to action, suicide prevention largely focuses on identifying and referring suicidal persons to mental health treatment and preventing reattempts (*6*). In addition to mental health conditions and prior suicide attempts, other contributing circumstances include social and economic problems, access to lethal means (e.g., substances, firearms) among persons at risk, and poor coping and problem-solving skills (*5*). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them can help reach the national goal, established by the National Action Alliance of Suicide Prevention and the American Foundation for Suicide Prevention, of reducing the annual suicide rate 20% by 2025 (*7*). To assist states in achieving this goal, CDC analyzed state-specific trends in suicide rates and assessed the multiple contributing factors to suicide; this report presents options for strategies to include in comprehensive suicide prevention efforts that are based on the best available evidence.

Methods

Suicide rates were analyzed for persons aged ≥10 years because determining suicidal intent in younger children can be difficult (*8*). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases, Tenth Revision,* underlying-cause-of death codes X60–X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive 3-year aggregate periods spanning 1999–2016 (1999–2001; 2002–2004; 2005–2007; 2008–2010; 2011–2013; and 2014–2016). Rate estimates were age-adjusted to the U.S. 2000 standard population and expressed

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per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same 3-year data aggregates, employing weighted least-squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes.

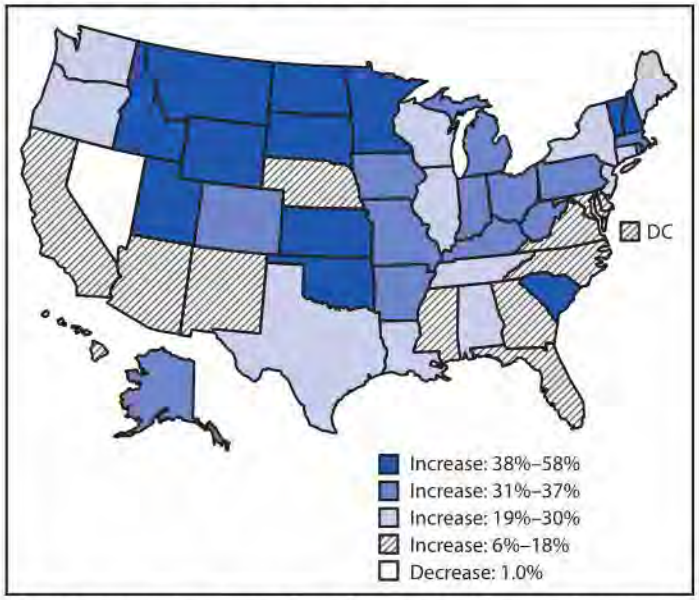
Characteristics of persons aged ≥10 years who died by suicide, with and without known mental health conditions, and the circumstances surrounding the suicides were compared in the 27 states* with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines mental health conditions as disorders and syndromes listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*9*), with the exception of problematic alcohol use and other substance use that are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. A range of circumstances (relationship problems, life stressors, and recent or impending crises) have been identified as potential risk factors for suicide in NVDRS. Circumstances captured are those identified as contributing to suicide in coroner/medical examiner or law enforcement reports, which reflect information provided by family and friends at the time of death. Decedents could have experienced multiple circumstances. Decedents with and without known mental health conditions were compared using chi-square tests. Logistic regression analyses were used to estimate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), controlling for sex, age group, and race/ethnicity.

Results

The most recent overall suicide rates (representing 2014–2016) varied fourfold, from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Across the study period, rates increased in all states except Nevada (where the rate was consistently high throughout the study period), with absolute increases ranging from 0.8 per 100,000 (Delaware) to 8.1 (Wyoming). Percentage increases in rates ranged from 5.9% (Delaware) to 57.6% (North Dakota), with increases >30% observed in 25 states (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785) (Figure).

Modeled suicide rate trends indicated significant increases in 44 states, among males (34 states) and females (43 states), as well as for the United States overall (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Nationally, the model-estimated average annual percentage change for the overall suicide rate was an increase of 1.5%. By sex, estimated national rate trends further indicated significant average annual percentage change increases for males (1.1%) and females (2.6%) (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785).

FIGURE. Percent change in annual suicide rate,* by state — United States, from 1999–2001 to 2014–2016



* Per 100,000 population, age-adjusted to the 2000 U.S. standard population.

Suicide decedents without known mental health conditions (11,039; 54.0%) were compared with those with known mental health conditions (9,407; 46.0%) for 27 states. Whereas decedents were predominantly male (76.8%) (Table 1) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely to be male (83.6% versus 68.8%; odds ratio [OR] = 2.3, 95% CI = 2.2–2.5) and belong to a racial/ethnic minority (OR range = 1.2–2.0). Suicide decedents without known mental health conditions also had significantly higher odds of perpetrating homicide followed by suicide (aOR = 2.9, 95% CI = 2.2–3.8). Among decedents aged ≥18 years, 20.1% of those without known mental health conditions and 15.3% of those with mental health conditions had previously served in the U.S. military or were serving at the time of death.

Whereas firearms were the most common method of suicide overall (48.5%), decedents without known mental health conditions were more likely to die by firearm (55.3%) and less likely to die by hanging/strangulation/suffocation (26.9%) or poisoning (10.4%) than were those with known mental health conditions (40.6%, 31.3%, and 19.8%, respectively). These differences remained significant in the adjusted models.

Toxicology testing was less likely to be performed for decedents without known mental health conditions. Among those with toxicology results, decedents without known mental health

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

TABLE 1. Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	**15,702 (76.8)**	6,469 (68.8)	9,233 (83.6)	<0.01	2.3 (2.2–2.5)	NA
Female	**4,744 (23.2)**	2,938 (31.2)	1,806 (16.4)	<0.01	0.4 (0.4–0.5)	NA
Age group (yrs)**						
10–24	**2,804 (13.7)**	1,211 (12.9)	1,593 (14.4)	<0.01	1.1 (1.1–1.2)	NA
25–44	**6,456 (31.6)**	3,036 (32.3)	3,420 (31.0)	<0.05	0.9 (0.9–1.0)	NA
45–64	**7,718 (37.7)**	3,820 (40.6)	3,898 (35.3)	<0.01	0.8 (0.8–0.8)	NA
≥65	**3,468 (17.0)**	1,340 (14.2)	2,128 (19.3)	<0.01	1.4 (1.3–1.5)	NA
Race/Ethnicity						
White, non-Hispanic	**17,102 (83.6)**	8,165 (86.8)	8,937 (81.0)	<0.01	0.6 (0.6–0.7)	NA
Black, non-Hispanic	**1,228 (6.0)**	411 (4.4)	817 (7.4)	<0.01	1.7 (1.5–2.0)	NA
American Indian/Alaska Native, non-Hispanic	**378 (1.8)**	112 (1.2)	266 (2.4)	<0.01	2.0 (1.6–2.6)	NA
Asian, non-Hispanic	**576 (2.8)**	235 (2.5)	341 (3.1)	<0.05	1.2 (1.1–1.5)	NA
Hispanic	**1,096 (5.4)**	463 (4.9)	633 (5.7)	<0.05	1.2 (1.0–1.3)	NA
Other	**66 (0.3)**	21 (0.2)	45 (0.4)	<0.05	1.8 (1.1–3.1)	NA
Extended demographics						
Ever served in military††	**3,429 (17.8)**	1,354 (15.3)	2,075 (20.1)	<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	**240 (1.2)**	104 (1.1)	136 (1.3)	NS	1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident type						
Single suicide	**20,063 (98.2)**	9,318 (99.1)	10,745 (97.4)	<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	**319 (1.6)**	64 (0.7)	255 (2.3)	<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	**64 (0.3)**	25 (0.3)	39 (0.4)	NS	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	**9,909 (48.5)**	3,821 (40.6)	6,088 (55.3)	<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	**5,907 (28.9)**	2,940 (31.3)	2,967 (26.9)	<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	**3,003 (14.7)**	1,861 (19.8)	1,142 (10.4)	<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	**1,021 (34.0)**	666 (35.8)	355 (31.1)	<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	**944 (31.4)**	608 (32.7)	336 (29.4)	NS	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	**800 (26.6)**	644 (34.6)	156 (13.7)	<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	**624 (20.8)**	468 (25.1)	156 (13.7)	<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	**219 (7.3)**	195 (10.5)	24 (2.1)	<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	**1,595 (7.8)**	780 (8.3)	815 (7.4)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)

See table footnotes on next page.

conditions were less likely to test positive for any substance overall (aOR = 0.8, 95% CI = 0.7–0.8), including opioids (aOR = 0.90, 95% CI = 0.81–0.99), but were more likely to test positive for alcohol (aOR = 1.2, 95%, CI = 1.1–1.3).

Information on circumstances surrounding suicide were available for all decedents with mental health conditions (9,407) and approximately 85% of those without known mental health conditions (9,357) in 27 states (Table 2). Persons without known mental health conditions were less likely to have any problematic substance use (aOR = 0.7, 95% CI = 0.7–0.8) than were persons with known mental health conditions. Whereas two thirds of decedents with known mental health conditions had a history of mental health or substance use treatment (67.2%), just over half (54.0%) were in treatment at the time of death.

Decedents without known mental health conditions had a significantly higher likelihood of any relationship problem/loss (45.1%) than did those with known mental health conditions (39.6%), specifically intimate partner problems (30.2% versus 24.1%), arguments/conflicts (17.5% versus 13.6%), and perpetrating interpersonal violence in the past month (3.0% versus 1.4%). Decedents without known mental health conditions were also more likely than were those with known mental health conditions to have experienced any life stressors (50.5% versus 47.2%) such as recent criminal legal problems (10.7% versus 6.2%) or eviction/loss of home (4.3% versus 3.4%) and were more likely to have had a recent or impending (within the preceding or upcoming 2 weeks, respectively) crisis (a current or acute event thought to contribute to the suicide) (32.9% versus 26.0%). All of these differences remained significant in the adjusted models. Physical health problems and job/financial problems were commonly contributing stressors among both persons without mental health conditions (23.2% and 15.6%, respectively) and those with mental health conditions (21.4%

TABLE 1. (*Continued*) Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Toxicology results						
Any toxicology testing	**13,317 (65.1)**	6,658 (70.8)	6,659 (60.3)	<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	**9,913 (74.4)**	5,192 (78.0)	4,721 (70.9)	<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected* **						
Alcohol						
Tested	**10,950 (53.6)**	5,409 (57.5)	5,541 (50.2)	<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	**4,442 (40.6)**	2,115 (39.1)	2,327 (42.0)	<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	**8,554 (41.8)**	4,258 (45.3)	4,296 (38.9)	<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	**2,279 (26.6)**	1,238 (29.1)	1,041 (24.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	**8,124 (39.7)**	4,226 (44.9)	3,898 (35.3)	<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	**2,464 (30.3)**	1,639 (38.8)	825 (21.2)	<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	**7,978 (39.0)**	3,866 (41.1)	4,112 (37.2)	<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	**499 (6.3)**	216 (5.6)	283 (6.9)	<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	**7,615 (37.2)**	3,696 (39.3)	3,919 (35.5)	<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	**736 (9.7)**	376 (10.2)	360 (9.2)	NS	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	**6,569 (32.1)**	3,127 (33.2)	3,442 (31.2)	<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	**1,471 (22.4)**	710 (22.7)	761 (22.1)	NS	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	**5,425 (26.5)**	3,103 (33.0)	2,322 (21.0)	<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	**2,214 (40.8)**	1,735 (55.9)	479 (20.6)	<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviations: CI = confidence interval; NA = not adjusted; NS = not significant; OR = odds ratio.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology testing.

*** Denominator for each positive group is the number tested for the substance in that group.

and 16.8%, respectively). Similarly, among all persons with recent crises, intimate partner problems were the most common types and did not differ by group.

Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR = 0.5, 95% CI = 0.4–0.5). Among those recently released, decedents without known mental health conditions were significantly more likely than decedents with mental health conditions to have been released from a correctional facility (25.7% versus 8.7%), hospital (43.7% versus 33.0%), or other facility, such as an alcohol/substance use treatment facility (24.2% versus 11.6%). Among decedents with known mental health conditions who were recently released from an institution, 46.7% were released from psychiatric facilities.

Decedents without known mental health conditions were significantly less likely to have a history of suicidal ideation (23.0%) or prior suicide attempts (10.3%) compared with those with known mental health conditions (40.8% and 29.4%, respectively). Suicide intent was disclosed by 22.4% and 24.5% of persons without and with known mental health conditions, respectively.

Conclusions and Comments

During 1999–2016, suicide rates increased significantly in 44 states, and 25 states experienced increases >30%. Rates increased significantly among males in 34 states, and females in 43 states. Additional research into the specific causes of these trends is needed. Data from the 27 states participating in NVDRS provide important insight into circumstances surrounding suicide and can help states identify prevention priorities.

TABLE 2. Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	**18,764 (91.8)**	9,407 (100)	9,357 (84.8)	<0.01	N/A	N/A
Mental health						
Any current diagnosed mental health condition**						
Depression/Dysthymia	—††	7,076 (75.2)	N/A	N/A	N/A	N/A
Anxiety disorder	—††	1,579 (16.8)	N/A	N/A	N/A	N/A
Bipolar disorder	—††	1,431 (15.2)	N/A	N/A	N/A	N/A
Schizophrenia	—††	509 (5.4)	N/A	N/A	N/A	N/A
PTSD	—††	424 (4.5)	N/A	N/A	N/A	N/A
ADD/ADHD	—††	226 (2.4)	N/A	N/A	N/A	N/A
Not specified	—††	760 (8.1)	N/A	N/A	N/A	N/A
Current depressed mood§§	**7,038 (37.5)**	3,962 (42.1)	3,076 (32.9)	<0.01	0.7 (0.6–0.7)	0.7 (0.6–0.7)
Problematic substance use						
Any	**5,319 (28.3)**	2,976 (31.6)	2,343 (25.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Alcohol	**3,268 (17.4)**	1,862 (19.8)	1,406 (15.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Other	**3,084 (16.4)**	1,768 (18.8)	1,316 (14.1)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Treatment						
Current mental health/substance use treatment	**5,141 (27.4)**	5,077 (54.0)	64 (0.7)	<0.01	0.01 (0.01–0.01)	0.01 (0.01–0.01)
Ever treated for mental health/substance disorder	**6,717 (35.8)**	6,323 (67.2)	394 (4.2)	<0.01	0.02 (0.02–0.02)	0.02 (0.02–0.03)
Relationship problems/loss						
Any relationship problem/loss	**7,948 (42.4)**	3,726 (39.6)	4,222 (45.1)	<0.01	1.3 (1.2–1.3)	1.3 (1.2–1.4)
Intimate partner problem	**5,098 (27.2)**	2,270 (24.1)	2,828 (30.2)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Perpetrator of interpersonal violence in past month	**414 (2.2)**	131 (1.4)	283 (3.0)	<0.01	2.2 (1.8–2.7)	2.0 (1.6–2.4)
Victim of interpersonal violence in past month	**84 (0.4)**	53 (0.6)	31 (0.3)	<0.05	0.6 (0.4–0.9)	0.8 (0.5–1.2)
Family relationship problem	**1,671 (8.9)**	873 (9.3)	798 (8.5)	NS	0.9 (0.8–1.0)	1.0 (0.9–1.1)
Other relationship problem (nonintimate)	**403 (2.1)**	202 (2.1)	201 (2.1)	NS	1.0 (0.8–1.2)	1.1 (0.9–1.3)
Argument or conflict (not specified)	**2,914 (15.5)**	1,278 (13.6)	1,636 (17.5)	<0.01	1.3 (1.2–1.5)	1.4 (1.3–1.5)
Death of a loved one (any)	**1,497 (8.0)**	826 (8.8)	671 (7.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–0.9)
Nonsuicide death	**1,181 (6.3)**	647 (6.9)	534 (5.7)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Suicide of family or friend	**379 (2.0)**	217 (2.3)	162 (1.7)	<0.01	0.7 (0.6–0.9)	0.8 (0.7–1.0)
Other life stressors						
Any life stressor	**9,171 (48.9)**	4,442 (47.2)	4,729 (50.5)	<0.01	1.1 (1.1–1.2)	1.1 (1.0–1.2)
Recent criminal legal problem	**1,588 (8.5)**	586 (6.2)	1,002 (10.7)	<0.01	1.8 (1.6–2.0)	1.7 (1.5–1.9)
Other legal problem	**748 (4.0)**	378 (4.0)	370 (4.0)	NS	1.0 (0.8–1.1)	1.0 (0.9–1.2)
Physical health problem	**4,179 (22.3)**	2,012 (21.4)	2,167 (23.2)	<0.01	1.1 (1.0–1.2)	1.0 (1.0–1.1)
Job/Financial problem¶¶	**2,941 (16.2)**	1,530 (16.8)	1,411 (15.6)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Eviction or loss of home	**722 (3.8)**	317 (3.4)	405 (4.3)	<0.01	1.3 (1.1–1.5)	1.4 (1.2–1.6)
School problem***	**162 (19.9)**	70 (17.8)	92 (21.9)	NS	1.3 (0.9–1.8)	1.3 (0.9–1.9)
Recent release from an institution†††	**1,412 (7.6)**	941 (10.2)	471 (5.1)	<0.01	0.5 (0.4–0.5)	0.5 (0.4–0.5)
Jail/Prison/Detention facility	**203 (14.4)**	82 (8.7)	121 (25.7)	<0.01	3.6 (2.7–4.9)	4.5 (3.2–6.4)
Hospital	**517 (36.6)**	311 (33.0)	206 (43.7)	<0.01	1.6 (1.3–2.0)	1.3 (1.0–1.7)
Psychiatric hospital/institution	**469 (33.2)**	439 (46.7)	30 (6.4)	<0.01	0.1 (0.1–0.1)	0.1 (0.1–0.1)
Other (includes alcohol/SU treatment facilities)	**223 (15.8)**	109 (11.6)	114 (24.2)	<0.01	2.4 (1.8–3.3)	2.5 (1.8–3.3)

See table footnotes on next page.

Suicidologists regularly state that suicide is not caused by a single factor (*5*); however, suicide prevention is often oriented toward mental health conditions alone with regard to downstream identification of suicidal persons, treatment of mental health conditions, and prevention of reattempts. This study found that approximately half of suicide decedents in NVDRS did not have a known mental health condition, indicating that additional focus on nonmental health factors further upstream could provide important information for a public health approach (*10*). Those without a known mental health condition suffered more from relationship problems and other life stressors such as criminal/legal matters, eviction/loss of home, and recent or impending crises.

Similarly, persons with mental health conditions also often experienced other circumstances such as relationship problems and job/financial or physical health problems that contributed to their suicide. These findings point to the need to both prevent the circumstances associated with the onset of mental health conditions and support persons with known mental health conditions to decrease their risk for poor outcomes (*11*). Two thirds of suicide decedents with mental health conditions had a history of treatment for mental health or substance use disorders,

TABLE 2. (*Continued*) Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Crisis within past or upcoming 2 weeks§§§	**5,525 (29.4)**	2,444 (26.0)	3,081 (32.9)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Intimate partner problem	**1,968 (35.6)**	854 (34.9)	1,114 (36.2)	NS	1.1 (0.9–1.2)	1.1 (0.9–1.2)
Physical health problem	**739 (13.4)**	315 (12.9)	424 (13.8)	NS	1.1 (0.9–1.3)	1.0 (0.8–1.2)
Criminal legal problem	**621 (11.2)**	203 (8.3)	418 (13.6)	<0.01	1.7 (1.5–2.1)	1.6 (1.3–1.9)
Family relationship problem	**430 (7.8)**	212 (8.7)	218 (7.1)	<0.05	0.8 (0.7–1.0)	0.9 (0.7–1.1)
Job problem	**354 (6.4)**	191 (7.8)	163 (5.3)	<0.01	0.7 (0.5–0.8)	0.7 (0.5–0.8)
Suicide event/history						
Left a note	**6,468 (34.5)**	3,182 (33.8)	3,286 (35.1)	NS	1.1 (1.0–1.1)	1.2 (1.1–1.2)
Disclosed suicide intent	**4,405 (23.5)**	2,306 (24.5)	2,099 (22.4)	<0.01	0.9 (0.8–1.0)	0.9 (0.8–0.9)
History of ideation	**5,990 (31.9)**	3,838 (40.8)	2,152 (23.0)	<0.01	0.4 (0.4–0.5)	0.4 (0.4–0.5)
History of attempts	**3,732 (19.9)**	2,770 (29.4)	962 (10.3)	<0.01	0.3 (0.3–0.3)	0.3 (0.3–0.3)

Abbreviations: ADD/ADHD = attention deficit disorder/attention deficit hyperactivity disorder; CI = confidence interval; N/A = not applicable; NS = not significant; OR = odds ratio; PTSD = posttraumatic stress disorder; SU = substance use.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was the reference group.

** Includes decedents with one or more diagnosed current mental health conditions, which are not mutually exclusive. Therefore, sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health conditions.

†† The specific type of mental health condition was calculated only among those with one or more known diagnosed mental health conditions.

§§ Not a diagnosis.

¶¶ Denominator is decedents aged ≥18 years.

*** Denominator is decedents aged 10–18 years.

††† Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.

§§§ Denominator of crisis subgroup is decedents with any crisis within past or upcoming 2 weeks. Crises depicted here represent the most commonly occurring categories.

with approximately half in treatment when they died. This finding suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities, such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. In addition, increased access to behavioral health providers in underserved areas is needed, as is expansion of health care systems that integrate physical and behavioral health, with a priority on suicide prevention and patient safety, especially through care transitions (*12*).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belonging and access to informational, tangible, emotional, and social support; and identifying and better supporting persons at risk (e.g., military veterans, persons with physical/mental health conditions) (*12*). Other strategies include creating protective environments (e.g., reducing access to lethal means among persons at risk for suicide, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for persons with mental health conditions and other life challenges), strengthening access to and delivery of care, supporting family and friends after a suicide, and encouraging the media to follow safe reporting recommendations (*12*). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (*10*).

The findings in this report are subject to at least three limitations. First, in the state-level analysis, rankings for four states (Maryland, Massachusetts, Rhode Island, and Utah) might have been affected by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward) or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml). Finally, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies that include more in-depth interviews with next-of-kin often identify greater attributions to mental health disorders

Summary

What is already known about this topic?

In 2016, nearly 45,000 persons died by suicide in the United States. Mental health conditions are one of several contributors to suicide.

What is added by this report?

During 1999–2016, suicide rates increased in nearly every state, including >30% increases in 25 states. 2015 data from 27 states indicate 54% of suicide decedents were not known to have mental health conditions. Relationship, substance use, health, and job or financial problems are among the other circumstances contributing to suicide.

What are the implications for public health practice?

A comprehensive approach using proven prevention strategies, such as those in CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, can help reach the national goal of reducing the annual suicide rate 20% by 2025.

(*13*); however, many methodological variations across studies exist (*14*). It is likely that some persons without known mental health conditions in the current study were experiencing mental health challenges that were unknown, undiagnosed, or not reported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (*12*) to better understand suicide in their populations, prioritize evidence-based comprehensive suicide prevention, and save lives.

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Conflict of Interest

No conflicts of interest were reported.

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II.1. MMWR DRAFT—Suicide Prevention [Title tbd]

Structured abstract (247/250 words)

Background: Suicide rates between 1999 and 2016 have increased significantly in the United States. Examining state-level trends and contributing circumstances of suicide can inform state prevention efforts.

Methods: Trends in age-adjusted suicide rates, by sex and state, among people aged 10 and older were calculated based on data from the National Vital Statistics System (NVSS, 1999-2016). Changes in rates and state rankings were assessed across six consecutive three-year periods (1999-2001, 2002-2004, 2005-2007, 2008-2010, 2011-2013, 2014-2016). Data from the 2015 National Violent Death Reporting System (NVDRS), across 27 states, were analyzed to assess differences between suicide decedents with and without known mental health problems.

Results: Average annual percentage change in suicide rates increased significantly in x# states, ranging from x% in x state to x% in x state, with an average rate change of xx% across the period. People with and without known mental health problems experienced a range of contributing circumstances to their suicides, including substance use, relationship problems, and multiple stressful life events.

Conclusions: Suicide rates have risen significantly across most states in the period 1999-2016. Numerous psychosocial factors contribute to suicide among people with and without known mental health problems.

Implications for Public Health Practice: To reverse trends in suicide across the nation, a population-based public health approach is needed. Specifically, comprehensive evidence-based strategies targeting all levels of society (individual, family, community), focused on preventing risk before it starts, identifying and supporting people already at risk, and caring for survivors, after a suicide is needed.

Text (1800 words)

INTRO

In 2016, more than x# suicides took place across the United States with a rate of xx per 100,000. Rates of suicide have increased across the lifespan among males and females, across racial/ethnic groups, and across urbanization levels.[1] [2] Rates of nonfatal attempts have also been on the rise, with emergency department visits for self-harm injury having increased more than 40% between 2001 and 2015.[3] In 2015, the economic toll of suicides and self-harm injuries totaled more than $69 billion in direct medical and work loss costs. These costs burden states and local communities as they struggle to take up the broad public health approach called for by the National Strategy for Suicide Prevention.[4] Such an approach entails preventing suicide risk before it occurs through evidence-based upstream prevention approaches such as strengthening economic supports and teaching coping and problem-solving skills, identifying and supporting people already at risk through training of gatekeepers and downstream crisis intervention and effective treatment, and caring for survivors in the aftermath of a suicide. To date, no single state has been able to take up such a comprehensive approach.

(194/~300 words)

METHODS

[1] NCHS Data brief
[2] Kegler et al 2017
[3] WISQARS Nonfatal injury reports
[4] DHHS

Suicide rate estimates and trend analyses exclude data for persons <10 years old. Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases 10th Revision* [ICD-10] underlying-cause-of death codes X60-X84, Y87.0, *U03). Age-specific population estimates were obtained from U.S. Census Bureau / National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive three-year aggregate periods covering years 1999-2016. Rate estimates were age-adjusted to the U.S. year 2000 standard population and expressed per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same three-year data aggregates, employing weighted least squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes (AAPCs).

Data from the 2015 National Violent Death Reporting System (NVDRS), from 27 states, were used to compare the characteristics, including precipitating circumstances, of suicide decedents with and without known mental health problems. NVDRS compiles data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports.

RESULTS

The most recent overall suicide rates (representing 2014-2016) ranged from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year, a four-fold difference (Table 1). Across the entire study period, rates increased in all but one state (Nevada), with increases ranging from +0.2 (Delaware) to +8.1 (Wyoming). Percentage increases in rates ranged from +5.9% (Delaware) to +57.6% (North Dakota), with percentage increases of at least 25% observed in over half of all states (30) as well as nationally. Geographically, many states showing the largest percentage increases are in the upper Great Plains and the upper Intermountain West (Map).

Modeled suicide rates trends were found to be significantly increasing for 44 states, as well as for the U.S. overall (Table 1). By sex, rate trends were found to be significantly increasing in 34 states for males and in 43 states for females. Nationally, the model-estimated AAPC for overall suicide rates was +1.5%. By sex, the national AAPC was +1.1% for males and +2.6% for females.

IV Calendar

June 5, 2018
Suicide

Step	Deliverable	Begin at 08:00 A.M.	End by COB	Workdays	Deliver to	Comments
	Analysis, Direction-setting, and MMWR Prep					
1	**(1) DIRECTION AND ANALYSIS: Initial Meeting**		TBD			
2	**OD Planning Document/SOHCO/One Thing**		DONE		RS, LS	
3	**CDC/OD review of ODPD/SOHCO/One Thing**		DONE			
4	**Program (PGM) respond in writing to questions from CDC/OD**		DONE		RS	
5	**(2) MMWR: MMWR draft(non-cleared)written and sent to VS team to help guide FS development during the RT discussion only**		2-Apr		RS	
6	**Pre-submission CIO-cleared MMWR due to VS team**		10-Apr			
7	**CDC/OD(Dir, Principal Depuy Dir, OADS, OADC); CSELS (Rasmussen, Kent)review pre-submission CIO-cleared and cross-cleared MMWR**	11-Apr	16-Apr	4	RS	MMWR and FS will be sent to CDC/OD at the same time.

8	**PGM revises, cross-clears and submits MMWR to Editors**	17-Apr	25-Apr	7	MMWR Submission System, RS, LS	Max 1800 word text 250 word abstract 15 references Submit to MMWR by noon Please send VS team a comment/response matrix on how you addressed comments from Drs. Schuchat, Mac Kenzie, and Lyon-Daniel. Matrix only needed for comments from these 3 reviewers
9	**MMWR edited and produced**	26-Apr	9-May	10	MMWR Editors and Reviewers, PGM, RS	
10	**SCIENCE CLIPS:** **PGM provides citations for Science Clips**		21-May		RS	
11	**Rich reviews citations and sends to OD/OADS and CDC librarian**		22-May		Bill Thomas John Iskander Gail Bang	
Fact Sheet (Word and Graphics Versions)						
12	**(3) FACT SHEET:** **Send FS (non-cleared) in Word (W) format to VS team**		2-Apr		LS, RS	
13	**Roundtable**	3-April 1:30-4:30			LS, RS	
14	**ClO-cleared post-RT FS(W) due to VS team**	4-Apr	10-Apr	5	LS, RS	
15	**CDC/OD (Dir, Principal Depuy Dir, OADS, OADC,PARP, PPEO); CSELS (Rasmussen, Kent, Royster, Martin); CDCW review ClO-cleared FS(W)**	11-Apr	16-Apr	4		

16	**Pgm revises FS(W) from CDC/OD, CSELS, CDCW comments and submits revised FS(W) to VS team**	17-Apr	25-Apr	7	RS,LS	Please send VS team a comment/response matrix on how you addressed comments from Drs. Schuchat, Mac Kenzie, and Lyon-Daniel. Matrix only needed for comments from these 3 reviewers
17	**Complete internal graphic development**	26-Apr	4-May	7	LS	
18	**CDC/OD (Principal Depuy Dir, OADS, OADC); CSELS (Kent); CDCW review full-color FS(G)**	4-May	Pre-brief with Principal Deputy Director, ADS, ADC (week of 5-Feb)		RS, LS	Principal Deputy Director, ADS, ADC will provide comments on FS, PR, telebriefing script,Q&A at the pre-brief Kent, CDCW will receive courtesy copies
19	**Work days: Final edits to FS(G)**	Pre-brief with Principal Deputy Director, ADS, ADC (week of 7-May)	17-May			
20	**HHS/ASPA review and clear full-color FS(G)**	18-May	24-May	5	LS to NMB to HHS/ASPA	Send FS with Press Release through NMB
21	**CDC Locks down full-color graphic FS(G)**		24-May		LS	at 5:00pm
22	**CDC final publication preparation (English and Spanish)**	25-May	4-Jun	6	LS	LS to send English FS to Shannon Omisore for Spanish translation Holiday 28-May
Other Materials Produced						

23	**Medical Outreach Program call**		while FS is being reviewed by OD		Brandy Peaker	Program to discuss with VS potential outreach strategies for clinicians
24	**(5) TOWN HALL MEETING PREP: PGM finds 2 local demo pgms for Town Hall Mtg**		8-May		OSTLTS: Chelsea Payne, Tonya Joyner	PGM works independently with OSTLTS for this
25	**(6) PRESS RELEASE (PR) and ONE GRAPHIC: Lynn receives draft, edits it, and sends revision back to PGM**		27-Apr		PGM	
26	**Pgm revises PR**	30-Apr	4-May	5	LS, DNEM	
27	**OADC reviews PR**	7-May	11-May	5		
28	**Pgm revises PR from OADC review**	14-May	17-May	4		
29	**HHS/ASPA receives and clears PR**	18-May	24-May	5	LS	
30	**PGM OKs ASPA changes to social media materials and PR**		25-May	1	LS	
31	**Lynn, graphics, and PGM to work on "one graphic" to go with PR**	18-May	24-May	5	LS	
32	**(7) DEAR COLLEAGUE LETTER: PGM writes/clears/submits**		27-Apr		LS	CD sends to MLS for Spanish translation
33	**(8) TELEBRIEFING SCRIPT and Q&A PGM writes/clears/submits**		27-Apr		LS	SO sends English script to Belsie Gonzalez for Spanish talking points
34	**(9) CRITICAL CONTACTS and EMAIL PGM writes/clears/submits**		27-Apr		RS/LS	
	Final Activities					
35	**(12) SOCIAL and ELECTRONIC MEDIA: Meet with Kamelya Hinson and PGM to go over Social and Electronic Media**		24-Apr		LS, DNEM,PGM	6 weeks prior to release; OADC to provide PGM with a social media template

36	**PGM to provide content to Kamelya Hinson; PGM works with LaKia Bryant to provide content on Digital Press Kit**		8-May		PGM, Kamelya Hinson, Arezoo Risman	4 weeks prior to release; PGM to work directly with OADC on social and electronic media. SO sends to MLS for Spanish translation
37	**(13) VS WEBSITE BUILT: PGM provides its links and alt text to LS**	25-May	31-May	4	LS, DNEM,PGM	Spanish Website also built Holiday 28-May
38	**Rich creates CDC Announcement**		29-May		Rhonda Smith	CDC Announcement released at 2pm on 6-Mar
39	**(14) PRE-BRIEFING: LS sends latest MMWR proof, FS/Graphics version, PR, Telebriefing Script, Q&A, Critical Contacts List and draft email**		4-May		LS	PGM to send all requested material by 10AM
40	**Pre-brief with Principal Deputy Director, ADS, ADC**		week of 7-May		In-person (unless traveling)	Bldg 21, 12th floor DIV: Leadership, Comm, Policy, Science SMEs Call in number provided
41	**Pre-brief with CDC Director**		week of 21-May		In-person (unless traveling)	Dir Conf Rm, Bldg 21, 12th floor DIV: Leadership, Comm, Policy, Science SMEs Call in number provided
42	**(15) NOTIFICATIONS: NPHIC call (PGM attends)**		31-May		LS, DNEM, PGM	
43	**Internal--Final materials sent to leadership and distributors**		4-Jun			Done by LS
44	**External - CDC Director sends out email to "Critical Contacts"**		5-Jun			Email should include that information is embargoed until 1pm on release date
45	**External (cont) - PGM sends email to "Critical Contacts" not otherwise contacted by CDC/OD**		5-Jun			Email should include that information is embargoed until 1pm on release date

46	**External (cont)--PGM and OSTLTS notify all other partners of impending release**		5-Jun			BRANCH: SME, Chief, Comm, Policy; Embargo in place until 1 pm
47	**(16) RELEASE** **Press receives materials under embargo**		5-Jun		RS, LS, DNEM	Embargo in place until 1pm
48	**CDC Director conducts telebriefing** **Materials released to public at 1pm**		5-Jun		TRF, LS, RS, OADC, PGM	Immediate Pre-brief 11:40; Telebrief at NOON, Dir Conf Rm, Bldg 21, 12th floor DIV: Director, Comm, Policy BRANCH: Chief, SME, Comm, Policy
49	**(17) MEDIA METRICS COLLECTED** **24-hour media report due**		6-Jun		LS, DNEM	
50	**30-day Media report due**		30 days after release		LS, DNEM	
51	**(18) OSTLTS TOWN HALL** **PGM participates**		12-Jun		OSTLTS	SME presents overview

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 13 Jul 2018 15:07:14 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: For Review by COB 8/17: suicide approach summaries for the implementation guidance
Attachments: SUI_Peer Norm Programs - for SME review.docx, SUI_Gatekeeper Training - for SME review.docx, SUI_Crisis Intervention - for SME review.docx

Hello,
We are in the home stretch of completing the implementation guidance for the TP's. One component of the guidance pertains to the specific approaches in the technical packages. We are down to the last 8 summaries – 7 of them are specific to the suicide TP. We put these on hold until after the Vital Signs – for obvious reasons!
Attached are 3 short ones for your review.
Lindsey is hoping to get this last batch into clearance ASAP – we are up against a contract deadline with Banyan. If you could review and send any comments/suggestions on the three attached by Tuesday COB, I'll incorporate your changes and get them ready for clearance.
The other ones that we need to finalize include:

- Postvention
- Safer suicide care through system change
- Treatment for people at risk of suicide
- Treatment for victims/survivors (which includes content across the technical packages)

Please let me know if you have any questions.
Thanks in advance for your help!
Linda

Peer Norm Programs

This approach seeks to make protective factors for suicide such as help seeking, reaching out and talking to trusted adults, behaviors that are normal and acceptable. It also focuses on promoting connectedness among peers, which can increase belonging, reduce isolation, build resiliency, and encourage adaptive coping behaviors. By leveraging the leadership qualities and social influence of peers, peer norm approaches are an important way to shift group-level beliefs and promote positive social and behavioral change.

Comment [DLL(]: Any suggestions for good, general resources to include here?

Strategy

- **Promote Connectedness** (Suicide)

Key Objectives	• Increase connectedness among peers and promote positive norms that protect against suicide • Strengthen bonds to schools, peers, and adults • Strengthen youth's leadership and social influence skills • Improve communication between youth and trusted adults
Implementation Considerations	• Programs are primarily delivered in school settings but may also be implemented in community settings • Programs are designed to be developmentally appropriate for youth in middle, high-school, and college • Programs are often delivered in groups and include social norm campaigns and active learning experiences to reinforce program concepts • Involving parents, school staff, or community members may also be important, depending on the specific program model • Implementers may need specialized education, training or certification, depending on the program
Key Stakeholders	• Public health • Education • Community organizations
Example Outcomes	• Increases in ○ healthy coping attitudes and behaviors ○ referrals for youth in distress ○ help-seeking behaviors ○ positive perceptions of adult support
Additional Resources	

Example Programs/Practices/Policies:

- Sources of Strength (Suicide)

Example Programs

Sources of Strength (Suicide)

Description: Sources of Strength is a youth suicide prevention project designed to use peer social networks to change unhealthy norms and culture. The mission of Sources of Strength is to prevent suicide by increasing help seeking behaviors and promoting connections between peers and caring adults. The program trains peer leaders, as well as adult advisors, to conduct messaging activities aimed at changing peer group norms around coping practices and problem behaviors. In addition, the program is designed to have a positive influence on the knowledge, attitudes and behaviors of the peer leaders.

Specific Populations/Settings	Key Partners	Considerations
• Population(s): Adolescents and young adults (ages 13-24 years) • Setting(s): School, community	• Public health agencies • School administrators and teachers • Community organizations	• Training and certification is required to deliver the program • Training materials, videos, and other resources are available • Consultation and technical assistance are available • Program cost available

Additional Information

- Sources of Strength Program Site - https://sourcesofstrength.org

Gatekeeper Training

This approach focuses on training individuals such as teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others in the community to identify and respond effectively to people who may be at risk of suicide. By identifying people at risk of suicide and linking them to appropriate support and care, gatekeeper training can positively impact suicide and risk factors for suicide such as depression and feelings of hopelessness.

Strategy

- **Identify and Support People at Risk** (Suicide)

Key Objectives	• Improve ability of gatekeepers to identify and understand the warning signs of suicide • Learn how to intervene appropriately and help people at risk of suicide • Increase knowledge of available resources and support
Implementation Considerations	• Programs may be implemented in a variety of settings (e.g., schools, university/campus, healthcare, community, military) • Many programs include specific guidance for the nature and sequencing of content to help gatekeepers feel comfortable with recognizing and inquiring about risk and facilitating access to support and care • Programs are often delivered in groups and use a combination of methods (e.g., group discussion, audiovisual learning aids, presentations) to provide opportunities to engage participants and practice skills • Training requirements vary depending on specific program model, ranging from a few hours to 2-5 days • Evidence of effectiveness also varies for different programs so it is important to review the evidence supporting a specific program before selecting one to implement
Sector Engagement	• Public health • Healthcare • Education • Government • Community organizations
Example Outcomes	• Reductions in ○ suicide deaths ○ suicide attempts ○ depression ○ feelings of hopelessness
Additional Resources	• Comparison Table of Suicide Prevention Gatekeeper Training Programs (Suicide Prevention Resource Center) http://www.sprc.org/sites/default/files/migrate/library/SPRC_Gatekeeper_matrix_Jul2013update.pdf

Example Programs/Practices/Policies:

- Applied Suicide Intervention Skills Training (Suicide)
- Garrett Lee Smith Suicide Prevention Program (Suicide)

Example Programs

Applied Suicide Intervention Skills Training (ASIST) (Suicide)

Description: ASIST is a training program for hotline counselors, emergency workers, clergy, caregivers and others in the community. The ASIST model has three phases of caregiving: connecting, understanding and assisting. In the first phase (connecting), participants learn how to identify people who are having thoughts of suicide. In the second phase (understanding), participants learn how to recognize the caller's invitation for help and how to listen to the caller's reasons for dying and living. In the third phase (assisting), participants learn how to conduct a safety assessment, develop a safety plan for the person at risk, and connect the person at risk to community resources. The ASIST training program has been field tested in a variety of settings.

Specific Populations/Settings	Key Partners	Considerations
• Population(s): Persons at risk of suicide • Setting(s): School, community, military	• Community organizations • Healthcare providers • Emergency medical services • Faith-based organizations • Government (local, state, federal) • School administrators and staff • Public health agencies	• 2-day training workshops are required to deliver the ASIST program • Materials and consultation support are available • Program cost available online

Additional Information

- ASIST Program Site - https://www.livingworks.net/programs/asist/
- Program Summary (SPRC) - http://www.sprc.org/resources-programs/applied-suicide-intervention-skills-training-asist

Garrett Lee Smith (GLS) Suicide Prevention Program (Suicide)

Description: Gatekeeper training is a core component of the Garrett Lee Smith (GLS) Suicide Prevention Program which has been implemented in states, territories, tribal communities, and college campuses across the United States. The program is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Individuals are trained to better recognize the risk for suicide, inquire about risk, intervene appropriately, and help the suicidal individual obtain assistance. Training ranges from a few hours to a few days.

Populations/Settings	Key Partners	Considerations
• Population(s): Persons at risk of suicide • Setting(s): School/college campuses, community	• Community organizations • School/campus administrators and staff • State mental health agencies • Government (local, state, federal) • Tribal communities • Public health agencies	To find the state or local GLS grantees in your community visit this website.

Additional Information

- SAMSHA – Garrett Lee Smith Suicide Prevention Program – http://www.samsha.gov

Crisis Intervention

This approach focuses on providing support and referral services, typically by connecting a person in crisis to trained volunteers and professional staff. Crisis intervention approaches are intended to impact key risk factors for suicide, including feelings of depression, hopelessness, and subsequent use of mental health care services. Crisis intervention can also put space and time between an individual who may be considering suicide and harmful behavior.

Strategy

- **Identify and Support People at Risk** (Suicide)

Key Objectives	• Provide critical support and services to persons at risk of suicide • Reduce risk factors for suicide
Implementation Considerations	• Crisis intervention services may be accessed through a telephone hotline, online chat, text messaging, or in-person • Education and awareness about how to seek help may also be made through public service announcements, billboards, brochures, and other materials in the offices of primary care and other providers • Duration of the intervention support varies depending on type of service and the immediate and long-term needs of the client • Some crisis intervention programs use trained volunteers; others use licensed professional staff
Sector Engagement	• Public health • Social services • Community organizations
Example Outcomes	• Reductions in ○ feelings of hopelessness ○ psychological pain ○ intent to die
Additional Resources	• Best Practices (Suicide Prevention Lifeline) - https://suicidepreventionlifeline.org/best-practices/ • Crisis Center Accreditation Program - http://www.suicidology.org

Example Programs/Practices/Policies:

- National Suicide Prevention Lifeline (Suicide)

Example Programs

National Suicide Prevention Lifeline (Suicide)

Description: The National Suicide Prevention Lifeline is a national network of local crisis centers that provides support to people in suicidal crisis or emotional distress. It also provides resources to family members and friends and best practice resources for professionals. The hotline operates 24/7 and is accessible by phone or a web-based chat function. Trained counselors are on-hand to listen, offer free and confidential emotional support, and provide referrals for mental health services in the local area.

Specific Populations/Settings	Key Partners	Considerations
• Population(s): Individuals in suicidal crisis or emotional distress • Setting(s): Virtual setting via telephone and/or web-chat	• Community organizations • Mental health providers • Health care providers • Public health agencies	• Lifeline Network Crisis Centers are accredited and follow written policies and guidelines addressing referral, training, and suicide risk assessment • Many centers offer other services, including training and educational resources in suicide prevention and wellness for their local communities • Crisis centers that are part of the National Lifeline Network also participate in Lifeline evaluation activities

Additional Information

- National Suicide Prevention Lifeline - https://suicidepreventionlifeline.org/

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: 9 Jun 2018 22:59:39 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Young, Joni (CDC/ONDIEH/NCIPC)
Subject: Fwd: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
Attachments: image002.emz

Congrats again to you all and everyone else. I've been hearing really great things from many of our partners. Please pass on the the wonderful feedback we've been getting. I'm going to share another in a moment.

From: Reed, Jerry
Date: June 9, 2018 at 2:27:46 PM EDT
To: Mercy, James (CDC/ONDIEH/NCIPC)
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

You all did a GREAT job on this. As a partner, I'm pleased we were able to spread the word. We got more media inquiry on this than anything I've seen in a long time. Tragically, the deaths of Kate Spade and Anthony Bourdain contributed to the significance of the findings. A heartbreaking week but you and your team and the leadership of the Center and CDC really made a very significant contribution to our collective contribution. Many thanks. It's always been a real pleasure working with you Jim.
Best,
Jerry

Jerry Reed, PhD, MSW
Senior Vice President for Practice Leadership
Suicide, Violence & Injury Prevention Portfolio Lead
National Action Alliance for Suicide Prevention Executive Committee Member
jreed@edc.org | 202-572-3771 (O) | 202-294-8132 (M) | 202-223-4059 (F)
Education Development Center, Inc.



From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 07, 2018 8:52 AM
To: Reed, Jerry
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Dear Jerry,
I would like to personally let you know that our new *Vital Signs*: *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* will be released later today. I believe that CDC's latest *Vital Signs* will support our collective efforts to reduce suicide rates by 20% by 2025 and would appreciate if you could help disseminate this publication to your networks once the

embargo lifts at 1:00 pm. I look forward to our continued partnership in support of a comprehensive public health approach to suicide prevention.
Jim

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

James A. Mercy, PhD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: 9 Jun 2018 23:02:06 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Young, Joni (CDC/ONDIEH/NCIPC)
Subject: Fwd: [EXTERNAL] EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
Attachments: image004.png

FYI - another congrats from the co-chair if the Action Alliance and Deputy Director of the Action Alliance.

From: Clancy, Carolyn
Date: June 9, 2018 at 4:39:59 PM EDT
To: Mercy, James (CDC/ONDIEH/NCIPC)
Subject: RE: [EXTERNAL] EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Belated congrats on fantastic rollout!

I brief our Acting Secretary later that day

Thank you for your leadership

Carolyn

Carolyn M Clancy MD
Executive in Charge
Veterans Health Administration
810 Vermont Ave, NW
Washington, DC 20420
202-461-7000

_____
From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 07, 2018 9:18:02 AM
To: Clancy, Carolyn
Cc: Bates, Alicia B.
Subject: [EXTERNAL] EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Dear Carolyn,

I would like to personally let you know that CDC's new Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates, will be released later today. As co-chair of the Action Alliance I thought you would be interested in this release, which includes state-level trends in suicide rates from 1999-2016, and looks at the circumstances of suicide among people with and without known mental health conditions, using data from CDC's National Violent Death Reporting System.

I believe that our latest Vital Signs will support our collective efforts to reduce suicide rates by 20% by 2025. I would appreciate if you could help disseminate this publication to your networks and colleagues once the embargo lifts at 1:00 pm. Thank you for your commitment to creating safer communities for future generations.

Jim

The CDC Vital Signs<http://www.cdc.gov/vitalsigns> series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.
This e-mail contains advance copies of several Vital Signs materials, including the Morbidity and Mortality Weekly Report (MMWR) article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. This latest edition of CDC Vital Signs will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.
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· A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the CDC Vital Signs information broadly with your colleagues and partners. Visit the Vital Signs Web page<http://www.cdc.gov/vitalsigns> to find the MMWR article, fact sheet, and other materials. Take advantage of CDC's social media tools<http://www.cdc.gov/socialmedia/tools/buttons/vitalsigns/index.html>, such as the Vital Signs buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication> and search on the term Vital Signs. We also invite you to join us for the Vital Signs Town Hall Teleconference<http://www.cdc.gov/stltpublichealth/townhall/> on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Thank you for your support.

[James A. Mercy, PhD Director Division of Violence Prevention National Center for Injury Prevention and Control]

James A. Mercy, PhD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control

James A. Mercy, PhD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 3 Jun 2018 13:29:02 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: FW: Is this a sufficient addition to the Suicide Prevention MMWR?

Hi Tom,
Read from highlighted email (about halfway down) up.
I think all is well.
I'm just waiting for a reply from Rich to my last email.
I thought Rich was going to send out an email to say, issue resolved.
Anyway, read below.
Deb

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Saturday, June 2, 2018 9:45 PM
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Subject: RE: Is this a sufficient addition to the Suicide Prevention MMWR?

Hi Rich,
Is this what you have in mind?

	1999			2016			
	suicides	pop	Incidence rate	suicides	pop	Incidence rate	%change
10-14	242	20213368	1.20	436	20618233	2.11	76.63
45-64	7977	60355862	13.22	16196	84249823	19.22	45.45
rate ratio			11.02			9.11	-17.33

The rates of youth (10-14) suicide have increased more than the rates of middle aged (45-64) suicide rates between 1999 and 2016, but middle aged adult suicide rates still outpace rates of youth suicide by 9:1.
Deb

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Saturday, June 2, 2018 8:12 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: RE: Is this a sufficient addition to the Suicide Prevention MMWR?

Good so far. I think the rate ratio of 9.1 is compelling.
Now we need to think about how to express it clearly so the public will get it.
Here's how I see it.
1. Compare the rates per 100k pop'n for the 2 groups at each of 2 points in time. This is the rate ratio of rates by group over time. The 9.1 ratio at one point in time is compelling and stands against any (wrong) perception that the change in youth should be the main focus.
2. What is the rate ratio at the second time, for each age group?
3. Using the incidence rates for each group at each of 2 times, what was the percent change in incidence over time in each of the 2 groups?

I think Anne was saying that a large percent change in an age group over time (#3 above) could be misleading if the incidences were small at both times for such an age group.
If I were providing this to Anne, I would likely develop a small table of these groups and its components. That is, for each of 2 age groups at each of 2 separate times, show counts, pop' n size, incidence, change in incidence as a percent change, and rate ratios. State your conclusion. I would send this to her and also hand it to her at our mtg Thurs. I think that would help her wrap her arms around the difference b/w the nchs quikstats and your paper.
Plz tell me if I' m missing something.
This is my advice, but your decision whether to do this or not.
Respectfully,
Rich

Rich Schieber, MD MPH
CAPT, USPHS

Director, CDC Vital Signs Program
RBS4@cdc.gov
404 697 9666

From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Date: June 2, 2018 at 7:33:00 PM EDT
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: Is this a sufficient addition to the Suicide Prevention MMWR?

Hi Rich,
Ok, thanks, glad no change is needed.
In 2016, for every one suicide among the 10-14 yo (n=436) group there were 37 suicides among the 45-64 yo group (n=16,196).
In terms of rates. The rate of the 45-64 y.o. group in 2016 (19.22/100,000) was 9.1x the rate of the 10-14 yo group (2.11/100,000).
However, since the 2016 population of people 45-64 (n=84,249,823) is so much larger than the population of 10-14 yo's (n=20,618,233), it would be more appropriate to compare the rate.
Deb

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Saturday, June 2, 2018 7:12 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: Is this a sufficient addition to the Suicide Prevention MMWR?

Yes, I can appreciate the confusion. It caught me off-guard as well. So just now I read the string again, and indeed she did find it satisfactory. So that' s that, and no further change to the MMWR needed for this point.

I would anticipate that she' ll ask us in the meeting just before the telebriefing begins, and/or she' ll be asked by the media, well, what about 10-14 yr olds? At that point, she should be able to refer to a q&a you have or will develop that shows the counts and their ratio for the 2 age groups. That is, for every 10-14 yr old who dies by suicide there' s X number of 45+ yr olds who die from suicide. And, per year of age, the older group is X times more likely to die by suicide than the younger group.
That way she wouldn' t need to get into a protracted mathematical discussion about why percent changes in incidence over time for one group may spuriously make people think that the problem is greater in the young.
What do you think?

Rich Schieber, MD MPH
CAPT, USPHS

Director, CDC Vital Signs Program
RBS4@cdc.gov
404 697 9666

From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Date: June 2, 2018 at 6:53:44 PM EDT
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: Is this a sufficient addition to the Suicide Prevention MMWR?

Hi Rich,
I'm a little confused. Last I knew on 5/15 Dr. Schuchat had approved this (email attached below):
Suicide rates have also increased among persons in all age groups <75 years, with the largest percent increase (45%; from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (n=232,108 between 1999 and 2016) occurring among adults aged 45-64 years.
Did something change that she wants the 10-14 yo group back in?
Deb

From: Schuchat, Anne MD (CDC/OD)
Sent: Tuesday, May 15, 2018 2:13 PM
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Cc: Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>; Glynn, Kate (CDC/OPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Iademarco, Michael (CDC/OPHSS/CSELS/OD) <mai9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Sorrells, Marjorie J. (CDC/OD/OCS) <isg8@cdc.gov>
Subject: RE: SUICIDE VS MMWR: Question about retaining the 45-64 yr olds with a percentage

This is fine now
From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Tuesday, May 15, 2018 2:08 PM

To: Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>
Cc: Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>; Glynn, Kate (CDC/OPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Iademarco, Michael (CDC/OPHSS/CSELS/OD) <mai9@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Sorrells, Marjorie J. (CDC/OD/OCS) <isg8@cdc.gov>
Subject: SUICIDE VS MMWR: Question about retaining the 45-64 yr olds with a percentage

Anne,

Sorry to bother you again.

All mention of the 10-14 yr olds has been removed. We weren't sure if you wanted ALL percentages removed, including the 45% highlighted below. VS and DVP think there's value to retaining the 45% increase attached to the 45-64 yr olds, and they've added the counts to the text. What do you think?

Current MMWR wording, after revision, is:

Suicide rates have also increased among persons in all age groups <75 years, with the largest percent increase (45%; from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (n=232,108 between 1999 and 2016) occurring among adults aged 45-64 years.

Thanks.

Rich

Richard Schieber, MD, MPH
Director, CDC Vital Signs Program

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Saturday, June 2, 2018 4:29 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>
Subject: Re: Is this a sufficient addition to the Suicide Prevention MMWR?

Tom,

Although Anne said "Thanks" last night, by which I assume the answer I sent was sufficient, I've had second thoughts. Here's what I think will satisfy all and put this to rest. Please consider these 2 alternatives.

1. Modify the Intro to specifically include national counts and rates, and percentage change over time, for youth 10-14 yrs or whatever years NCHS has highlighted. Use the same dates y0u used for the overall national and 45-64 yr olds. Since it's in the Intro and not the Results, you could comment there that the 10 yr olds catch attn b/c of the high rates, but that's a mathematical artifact and not a true high-suicide group based on their low counts.

2. Alternatively, you could use your analysis to indicate the same thing in the Discussion. Either way, the issue is covered.

What do you think?

Rich

Rich Schieber, MD MPH
CAPT, USPHS

Director, CDC Vital Signs Program
RBS4@cdc.gov
404 697 9666

From: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Date: June 2, 2018 at 8:46:52 AM EDT
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: FW: Is this a sufficient addition to the Suicide Prevention MMWR?

Hi Rich,

Thank you for sending the response to Dr. Schuchat last night. I just wanted to remind you about this earlier exchange where she had approved inclusion in the introduction. Hopefully, that will still work for her.

-Tom

From: Schuchat, Anne MD (CDC/OD)
Sent: Saturday, May 12, 2018 2:25 PM
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Sorrells, Marjorie J. (CDC/OD/OCS) <isg8@cdc.gov>; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>; Glynn, Kate (CDC/OPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Iademarco, Michael (CDC/OPHSS/CSELS/OD) <mai9@cdc.gov>
Subject: Re: Is this a sufficient addition to the Suicide Prevention MMWR?

Yes. Can you share what reference 3 is? The reader will be shocked about the 10 to 14 age group so I would look up the reference if I were reading the article to see what the rates are. If it's hard to find in reference 3 we may want to mention what those absolute rates went from as i assume much begged absolute increase in the adult group. Ie 30percent increase from very low absolute rate not quite as alarming as when it's from already big numbers.

Sent from my iPhone

On May 12, 2018, at 12:15 PM, Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov> wrote:

> Anne,
> The Suicide Prevention program is asking whether or not the boldfaced sentence at the bottom of this
> message, once added to the MMWR Introduction seen there, is sufficient to answer your query about suicide rates by age and make its point.
> If not, please let us know what additional analyses would be needed, and the pgm will see what they can do.
> Thanks.

Rich

Rich Schieber, MD
(404) 697-9666
R_Schieber@comcast.net

BACKGROUND AND PURPOSE

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (1). Between 1999 and 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (2,3). **Suicide rates have increased among all age groups younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14 (3)**. Suicide is the 10th leading cause of death and is one of just three leading causes that are increasing (1,4). Additionally, rates of emergency department visits for nonfatal self-harm, a key risk factor for suicide, increased 42% between 2001 and 2015 (1). Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs (1).

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: 4 Jun 2018 09:41:00 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: FW: 290988 - COMPLETED - Suicide Technical Package- Spanish translation
Attachments: Suicide Technical Package_SPANISH_draft pending MLS approval.pdf

Greetings:

For your information.

Alex C

From: Young, Joni (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 8:52 AM
To: Mercado-Crespo, Melissa (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Gervin, Derrick (CDC/ONDIEH/NCIPC)
Subject: FW: 290988 - COMPLETED - Suicide Technical Package- Spanish translation

Hi Melissa and Asha,

Good news...the Spanish translation of the Suicide Technical Package is almost complete! I asked if Sarah could share the latest version so that you both can start using it as a reference (see attached) The final version should be ready soon and will be posted on the internet. Please think about whether we need to order print versions.

Thanks,

Joni

From: Roby, Sarah (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 8:37 AM
To: Young, Joni (CDC/ONDIEH/NCIPC) <gzc8@cdc.gov>
Subject: RE: 290988 - COMPLETED - Suicide Technical Package- Spanish translation

Hi Joni,

Attached is the PDF file with the Suicide Technical Package. I know this is in a hurry, so note that the final quality assurance check from MLS has not been completed yet- I sent it to them this morning. It will be posted to web pages as soon as MLS signs off.

Thanks,

Sarah

From: Young, Joni (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 10:24 AM

To: Roby, Sarah (CDC/ONDIEH/NCIPC) <mkq4@cdc.gov>
Subject: Re: 290988 - COMPLETED - Suicide Technical Package- Spanish translation

Thanks, Sarah!

From: Roby, Sarah (CDC/ONDIEH/NCIPC) <mkq4@cdc.gov>
Date: June 1, 2018 at 10:23:09 AM EDT
To: Young, Joni (CDC/ONDIEH/NCIPC) <gzc8@cdc.gov>
Subject: Re: 290988 - COMPLETED - Suicide Technical Package- Spanish translation

Hi Joni,

I emailed Alida. She will need to export the graphic design file to a PDF, but that shouldn't take too long. Keep you posted!

Thanks,

Sarah

From: Young, Joni (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 31, 2018 5:08:28 PM
To: Roby, Sarah (CDC/ONDIEH/NCIPC)
Subject: RE: 290988 - COMPLETED - Suicide Technical Package- Spanish translation

Hi Sarah,

I know that Alida is probably still working on the layout, but am wondering if the translation draft can be shared with Melissa Mercado-Crespo and Asha Ivey-Stevenson at this point. They are starting to look at providing TA to Puerto Rico and I think it would be helpful if they can start to look at that.

Thanks,

Joni

From: Roby, Sarah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 23, 2018 3:37 PM
To: Young, Joni (CDC/ONDIEH/NCIPC) <gzc8@cdc.gov>
Subject: FW: 290988 - COMPLETED - Suicide Technical Package- Spanish translation

Hi Joni!

Great news! The Suicide TP is done with translation and I am sending on to Alida for layout. I will keep you posted on timeline from her.

Talk soon,

Sarah

From: Roby, Sarah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 23, 2018 3:35 PM
To: Gonzalez, Celina (CDC/OD/OADC) (CTR) <xbs9@cdc.gov>
Cc: CDC Multilingual Translations <translations@cdc.gov>
Subject: RE: 290988 - COMPLETED - Suicide Technical Package- Spanish translation

Hi Celina,

Thank you so much for sending this along! It will be made available on our website as a PDF, so prior to launch I will be sure to send you a copy for QA check.

Best wishes,

Sarah

Sarah J. Roby

Health Education Specialist

Office of the Director, Health Communication and Education Team

Division of Violence Prevention

National Center for Injury Prevention and Control

Centers for Disease Control and Prevention

Phone: (404) 498-1375

Email: mkq4@cdc.gov



Preventing Injuries and Violence
Through Science and Action



From: Gonzalez, Celina (CDC/OD/OADC) (CTR)
Sent: Wednesday, May 23, 2018 2:36 PM
To: Roby, Sarah (CDC/ONDIEH/NCIPC) <mkq4@cdc.gov>
Cc: CDC Multilingual Translations <translations@cdc.gov>
Subject: RE: 290988 - COMPLETED - Suicide Technical Package- Spanish translation

Dear Sarah,

Attached is the translation in .idml format as requested in order 290988.

This order is now completed and closed.

At the end of the file we added the following text as a stamp of approval and tracking record for the CDC Multilingual Services team: MLS–290988.

If you intend to do any desktop publishing to this translation or plan to make it available from the Internet or other media, please let us do a final QA check prior to its release to production to assure that the quality of the product has been kept.

For web posting, please remember to add the MLS order number as meta tag of your page (refer to WCMS instructions), also add "translated by CDC Multilingual Services" as part of the content source, for instance:

Fuente del contenido: Centros para el Control y la Prevención de Enfermedades, traducido por CDC Multilingual Services #290988.

Let us know how we are doing. Your feedback will help us improve the services we provide.

Thank you for using the CDC Multilingual Services. We look forward to working with you again soon.

Regards,

Celina González Posse

Bilingual Publications Analyst

ATA Certified Translator

Northrop Grumman Information Systems

CDC Multilingual Services

Email: xbs9@cdc.gov

Phone: 404-639-3764

Mobile: 201-233-1422

Telework: Mondays, Wednesdays and Thursdays from 9:00 to 5:30

On site: Tuesdays and Fridays from 7:00 to 3:30

From: Hamilton, Maria (Natalia) (CDC/OD/OADC)
Sent: Monday, May 21, 2018 9:13 AM
To: Gonzalez, Celina (CDC/OD/OADC) (CTR) <xbs9@cdc.gov>
Subject: FW: 290988 - CERTIFIED - Suicide Technical Package- Spanish translation

Celina,

This translation is certified.

Regards,

Natalia Hamilton

Language Specialist

CDC Multilingual Services/DCS/ OADC

Office of the Associate Director for Communication

email: vof4@cdc.gov

(tel) 404 639 3938, (cell) 404 542 1442

CLFT Bldg 19 Cube B110.08

MS-G21

Telework Days: Tuesday, Thursday & Friday

From: Gonzalez, Celina (CDC/OD/OADC) (CTR)
Sent: Wednesday, April 25, 2018 12:49 PM
To: Hamilton, Maria (Natalia) (CDC/OD/OADC) <vof4@cdc.gov>
Subject: 290988 - TRANSLATED - Suicide Technical Package- Spanish translation

Natalia,

This has been translated and is ready to be certified.

Thank you,

Celina

From: Communication Services (CDC)
Sent: Friday, April 06, 2018 1:06 PM
To: Gonzalez, Celina (CDC/OD/OADC) (CTR) <xbs9@cdc.gov>
Subject: Create-IT Email - Job Assignment Notice

You have been assigned to job: 290988-A







Prevención del suicidio:

Paquete técnico de políticas, programas y prácticas

National Center for Injury Prevention and Control
Division of Violence Prevention

Prevención del suicidio:

Paquete técnico de políticas, programas y prácticas

Autores:

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Kristin Holland, PhD, MPH
Brad Bartholow, PhD
Alex Crosby, MD, MPH
Shane Davis, PhD
Natalie Wilkins, PhD

2017

División de Prevención de la Violencia
Centro Nacional para la Prevención y el Control de Lesiones
Centros para el Control y la Prevención de Enfermedades
Atlanta, Georgia

Centros para el Control y la Prevención de Enfermedades
Anne Schuchat, MD (RADM, USPHS), directora interina

Centro Nacional para la Prevención y el Control de Lesiones
Debra E. Houry, MD, MPH, directora

División de Prevención de la Violencia
James A. Mercy, PhD, director

Citación sugerida:

Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). *Preventing Suicide: A Technical Package of Policies, Programs, and Practices.* Atlanta, GA: Centro Nacional para la Prevención y el Control de Lesiones, Centros para el Control y la Prevención de Enfermedades.

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Agradecimientos

Deseamos agradecer a las siguientes personas, que contribuyeron de maneras específicas con la preparación de este paquete técnico. Agradecemos en particular a Linda Dahlberg por su visión, orientación y apoyo a lo largo de la creación de este paquete. Asimismo, agradecemos a los directivos de la división, el centro y los CDC por su cuidadosa revisión y las útiles observaciones que nos brindaron en las versiones anteriores de este documento. Le agradecemos a Alida Knuth por su pericia en el formateo y diseño. Y por último, queremos dar las gracias y expresar nuestra gratitud a todos los revisores externos por sus útiles observaciones, el apoyo que nos mostraron y el ánimo que nos dieron para la creación de este recurso.

Revisores externos

Casey Castaldi
Prevention Institute

Carmen Clelland
Oficina de Apoyo Estatal, Tribal, Local y Territorial
Centros para el Control y la Prevención de Enfermedades

Amalia Corby-Edwards
Asociación Estadounidense de Sicología

Rachel Davis
Prevention Institute

Pamela End of Horn
Sede del Servicio de Salud para Indígenas

Craig Fisher
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Keita Franklin
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Linda Langford
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Richard McKeon
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Christine Schuler
Instituto Nacional para la Seguridad y Salud Ocupacional, Centros para el Control y la Prevención de Enfermedades

Morton Silverman
Education Development Center, Inc.

Ellyson Stout
Education Development Center, Inc.

Hope M. Tiesman
Instituto Nacional para la Seguridad y Salud Ocupacional, Centros para el Control y la Prevención de Enfermedades

Se cita el nombre de los expertos anteriores con la afiliación que tenían al momento de la revisión de este documento.



Reseña

Este paquete técnico presenta un grupo selecto de estrategias basadas en la mejor evidencia disponible, para ayudar a las comunidades y los estados a centrar su enfoque en las actividades de prevención que tienen el mayor potencial para prevenir el suicidio. Estas estrategias incluyen el fortalecimiento de los apoyos económicos; el fortalecimiento del acceso a los cuidados relacionados con el suicidio y de su prestación; la creación de ambientes protectores; el fomento de la conexión; la enseñanza de destrezas de superación y resolución de problemas; identificación de las personas en riesgo y provisión de apoyo; y reducción de los daños y prevención del riesgo futuro. En este paquete se incluyen estrategias que se enfocan en prevenir el riesgo de suicidio en primer lugar, así como enfoques cuyo objetivo es reducir los daños inmediatos y a largo plazo del comportamiento suicida en las personas, las familias, las comunidades y la sociedad. Las estrategias contenidas en este paquete técnico apoyan las metas y los objetivos del informe *Estrategia Nacional para la Prevención del Suicidio*[1] y la prioridad de fortalecer la prevención a nivel de comunidad conferida por la Alianza Nacional de Acción para la Prevención del Suicidio.[2] La implementación exitosa de este paquete se puede lograr mediante el compromiso, la cooperación y el liderazgo de diversos sectores, entre ellos los de salud pública, educación, justicia, atención médica, servicios sociales, comercio, trabajo y gobierno.

¿En qué consiste un paquete técnico?

Un paquete técnico es la recopilación de un conjunto básico de estrategias para reducir un factor de riesgo o resultado específico y mantener esa reducción.[3] Los paquetes técnicos ayudan a las comunidades y a los estados a dar prioridad a las actividades de prevención con base en la mejor evidencia disponible. Este paquete técnico tiene tres componentes. El primer componente son las ***estrategias*** (o la dirección o medidas preventivas) para lograr la meta de prevenir el suicidio. El segundo componente son los ***enfoques***. Los enfoques incluyen las formas específicas de impulsar las estrategias. Este impulso se puede lograr a través de *programas, políticas y prácticas*. Y como tercer componente se incluye para cada enfoque la ***evidencia*** sobre la prevención del suicidio o los factores de riesgo relacionados. Este paquete tiene el objetivo de servir como recurso para orientar y fundamentar la toma de decisiones relativas a la prevención, tanto en las comunidades como en los estados.

La prevención del suicidio es una prioridad

El suicidio, conforme la definición de los Centros para el Control y la Prevención de Enfermedades (CDC), es parte de una clase más amplia de comportamientos denominada *violencia autoinfligida*. Se entiende por violencia autoinfligida un comportamiento dirigido hacia uno mismo, cuyo resultado deliberado es la lesión o el *potencial* de causar una lesión.[4] Esta violencia autoinfligida puede ser de carácter *suicida* o *no suicida*. Para los fines de este documento, nos referimos solamente a aquellos comportamientos que tienen por objetivo el suicidio:

- **Suicidio** es la muerte causada por un comportamiento perjudicial dirigido hacia uno mismo, adoptado con la intención de morir a causa de dicho comportamiento.
- **Intento de suicidio** se define como un comportamiento *no mortal,* potencialmente perjudicial, dirigido hacia uno mismo, adoptado con la intención de morir a causa de dicho comportamiento. Los intentos de suicidio pueden o no tener como resultado una lesión.

La prevalencia del suicidio es alta. El suicidio presenta un desafío importante para la salud pública en los Estados Unidos y en el mundo. Contribuye a la muerte prematura, la morbilidad, la pérdida de productividad y a costos en términos de atención médica. [1,5] En el 2015 (el año más reciente para el cual se tienen datos de muertes), el suicidio fue responsable de 44 193 muertes en los Estados Unidos, lo cual se traduce a aproximadamente 1 muerte cada 12 minutos.[6] También en el 2015, el suicidio fue la 10.ª causa principal de muerte y ha estado entre las 12 principales desde 1975 en los Estados Unidos.[7] Las tasas de suicidio en general aumentaron el 28 % entre el 2000 y el 2015.[6] El suicidio es un problema que afecta a las personas durante toda la vida; es la tercera principal causa de muerte entre los jóvenes de 10 a 14 años, la segunda causa de muerte entre las personas de 15 a 24 años y las de 25 a 34, la cuarta entre las personas de 35 y 44 años, la quinta entre las personas de 45 a 54 años y la octava entre las personas de 55 y 64 años.[6]



Las tasas de suicidio varían por raza u origen étnico, edad y otras características poblacionales. Entre los grupos poblacionales con las tasas de suicidio más altas durante toda la vida se encuentran el de indoamericanos y nativos de Alaska (AI/AN) no hispanos y el de personas blancas no hispanas. Las tasas de suicidio para estos dos grupos en el 2015 fueron 19.9 y 16.9 por cada 100 000 personas respectivamente.[6] Otros grupos poblacionales que se vieron afectados desproporcionadamente son el de adultos de mediana edad (cuya tasa aumento el 35 % entre el 2000 y el 2015, con aumentos pronunciados tanto entre los hombres [29 %] como entre las mujeres [53 %] de 35 a 64 años);[6] el de veteranos y otro personal militar (cuya tasa de suicidio casi se duplicó entre el 2003 y el 2008 y, por primera vez en décadas, superó la de suicidio entre civiles);[8, 9] el de trabajadores de ciertos grupos ocupacionales;[10, 11] y el de jóvenes sexuales de minorías que, comparados con los no sexuales de los mismos grupos, mostraron mayor ideación y comportamiento suicida.[12-14]

Las tasas de suicidio reflejan solamente una porción del problema.[15] Hay una cantidad considerablemente más alta de personas que terminan en el hospital por comportamientos suicidas no mortales (o sea, intentos de suicidio) que de personas con lesiones mortales, y una cantidad aun más alta que recibe tratamiento en un entorno ambulatorio (por ejemplo, en la sala de emergencias) o que no recibe ningún tratamiento.[15] Por ejemplo, durante el 2014, entre los adultos de 18 años o mayores, por cada uno que se suicidó hubo 9 que recibieron tratamiento en una sala de emergencias por lesiones autoinfligidas, 27 que reportaron haber intentado suicidarse y más de 227 que reportaron haberlo considerado seriamente.[6, 16]

El suicidio se asocia a varios factores de riesgo y de protección. Al igual que los otros comportamientos humanos, el suicidio no tiene una causa determinante única. Ocurre como respuesta a la interacción de varias influencias biológicas, sicológicas, interpersonales, ambientales y sociales, generalmente, a lo largo del tiempo.[1, 5] El modelo ecológico social, que abarca varios niveles de enfoque —individual, relacional, comunitario y social—, es un marco útil para el análisis y la comprensión del riesgo de suicidio y de los factores de protección que se han identificado en la literatura.[17] Existen factores de riesgo y de protección en cada uno de estos niveles. Los factores de riesgo incluyen, por ejemplo:[1, 5]

- **En el nivel individual**: antecedentes de depresión y de otras enfermedades mentales, desesperanza, abuso de sustancias, ciertas afecciones, intentos de suicidio anteriores, ser víctima o perpetrador de violencia, y determinantes genéticos y biológicos.
- **En el nivel relacional**: relaciones altamente conflictivas o violentas, sensación de aislamiento y de falta de apoyo social, antecedentes de suicidio de un familiar o ser querido, estrés financiero o laboral.
- **En el nivel comunitario**: inadecuada conexión con la comunidad, barreras para la atención médica (por ejemplo, falta de acceso a proveedores y medicamentos).
- **En el nivel social**: disponibilidad de medios letales para cometer el suicidio, representaciones del suicidio en los medios de manera no segura, estigma relacionado con buscar ayuda y con la enfermedad mental.

Es importante reconocer que la gran mayoría de las personas que están deprimidas, que intentan suicidarse o que tienen otros factores de riesgo, *no* mueren por suicidio.[18, 19] Asimismo, la relevancia de cada factor de riesgo puede variar por edad, raza, género, orientación sexual, lugar geográfico de residencia y estatus sociocultural y económico.[1, 5]



También se pueden encontrar factores de protección, o sea, influencias que amortiguan el riesgo de suicidio, en cada nivel del modelo social ecológico. Entre los factores de protección que se han identificado en la literatura se incluyen las destrezas eficaces para la superación y resolución de problemas, las objeciones morales al suicidio, una relación fuerte y de apoyo con la pareja, los amigos y la familia; la conexión con la escuela, la comunidad y otras instituciones sociales; la disponibilidad de atención médica física y mental de calidad y continua; y un acceso reducido a medios letales.[1, 5] Estos factores de protección pueden, contrarrestar un factor de riesgo determinado o actuar como amortiguadores contra un número de riesgos que se asocian al suicidio.

El suicidio tiene relación con otras formas de violencia. La exposición a violencia (por ejemplo, a maltrato y abandono infantil, acoso, violencia de semejantes, violencia en las relaciones sentimentales, violencia sexual y violencia en la pareja íntima) se asocia a un mayor riesgo de depresión, trastorno por estrés postraumático (TEPT), ansiedad, suicidio e intentos de suicidio.[20-26] Las mujeres expuestas a violencia en la pareja tienen 5 veces más probabilidades de intentar suicidarse que las no expuestas a esta violencia.[26] La exposición a experiencias adversas en la infancia, como al abandono y maltrato físico, sexual y emocional, y vivir en un hogar con problemas de violencia, salud mental, abuso de sustancias y otras formas de inestabilidad, se asocian también a un mayor riesgo de suicidio e intentos de suicidio.[22, 27] Los efectos sicosociales de la violencia en la infancia y la adolescencia pueden observarse décadas después, e incluyen problemas graves con las finanzas, la familia, el trabajo y de estrés, los cuales son factores que pueden aumentar el riesgo de suicidio. El suicidio frecuentemente tiene los mismos factores de riesgo individuales, relacionales, comunitarios y sociales que otras formas de violencia, lo cual parece indicar que los esfuerzos para prevenir la violencia interpersonal podrían también ser útiles para prevenir el suicidio.[28-30] Los CDC han creado paquetes técnicos para las distintas formas de violencia interpersonal a fin de ayudar a que las comunidades identifiquen estrategias y enfoques adicionales (https://www.cdc.gov/violenceprevention/pub/technical-packages.html). De la misma manera que el suicidio puede compartir factores de riesgo con la violencia interpersonal, los factores de protección también se pueden superponer. Por ejemplo, para una persona, el hecho de estar conectada con su comunidad,[31] escuela,[32] familia,[33] adultos interesados por su bienestar,[34, 35] y semejantes prosociales[36] puede mejorar su resiliencia y ayudar a reducir su riesgo de suicidio y de otras formas de violencia.



Las consecuencias derivadas del suicidio en la economía y la salud son considerables. El suicidio y los intentos de suicidio tienen consecuencias profundas en las personas, las familias y las comunidades.[37-40] En un estudio inicial, Crosby y Sacks[41] estimaron que el 7 % de la población adulta de los Estados Unidos, o sea, 13.2 millones de adultos, conocía a alguien que había muerto por suicidio en los 12 meses anteriores. También estimaron que por cada suicidio, 425 adultos estaban expuestos o sabían de la muerte.[41] En un estudio más reciente, en un estado, Cerel et al[42] hallaron que el 48 % de la población había conocido a lo largo de su vida a al menos una persona que había muerto por suicidio. Las investigaciones indican que el efecto de haber conocido a alguien que haya muerto por suicidio o de haber vivido la experiencia (o sea, haber intentado suicidarse, haber tenido pensamientos suicidas o haber sido afectado por la muerte de alguien a causa del suicidio) va mucho más allá de las lesiones y la muerte. Las personas que han vivido la experiencia podrían sufrir consecuencias a largo plazo, tanto físicas como de salud mental. Estas varían desde enojo y culpabilidad hasta impedimentos físicos, según el medio que hayan usado y la gravedad del intento.[43] De manera similar las personas que sobreviven el suicidio de un ser querido pueden padecer dolor y sufrimiento continuo, como duelo complicado,[44] estigma, depresión, ansiedad, trastorno por estrés postraumático y mayor riesgo de ideación suicida y suicidio.[45, 46] También existen efectos financieros y ocupacionales para los sobrevivientes que, aunque se hable menos de estos, no tienen menor importancia.[47]

El suicidio también causa un daño económico inmenso en la sociedad. Según estimaciones moderadas, el costo del suicidio en el 2013 fue de 50 800 millones de dólares solamente en concepto de costos médicos y trabajo perdido de por vida.[47] Tras hacer ajustes por la posible cantidad de suicidios no reportados y teniendo en cuenta los gastos de salud per cápita, el producto interno bruto per cápita y la variabilidad de los gastos de salud e ingresos per cápita de los estados, otro estudio estimó que los costos de por vida asociados a las lesiones no mortales y a las muertes causadas por la violencia autoinfligida eran de aproximadamente 93 500 millones, también para el 2013.[48] La abrumadora carga de estos costos provino de la pérdida de productividad durante el curso de la vida, con un costo promedio por suicidio de más de 1.3 millones de dólares.[48] Es probable que los costos económicos reales sean más altos, ya que ninguno de los estudios incluyó cifras monetarias en relación con los otros costos sociales, como aquellos derivados del dolor y sufrimiento de los miembros de la familia, ni con otros de los efectos.

El suicidio se puede prevenir. Al igual que la mayoría de los problemas de salud pública, el suicidio es prevenible.[1,5] Aunque se seguirán logrando avances para el futuro, en la actualidad existe evidencia que fundamenta numerosos programas, prácticas y políticas, y hay muchos programas ya listos para ser implementados. De la misma manera que el suicidio no es causado por un factor único, las investigaciones parecen indicar que tampoco se logrará una reducción en el suicidio mediante una estrategia o un enfoque único.[1, 49] Más bien, la mejor manera de lograr la prevención del suicidio es mediante un enfoque que abarque los niveles individual, relacional, familiar, comunitario y social, y todos los sectores, tanto privados como públicos.[1, 5]

Evaluación de la evidencia

Este paquete técnico incluye programas, prácticas y políticas que han dado evidencia de tener un impacto en el suicidio, o en los factores de riesgo de suicidio o de protección contra el suicidio. Para que se consideraran para su inclusión en este paquete técnico, los programas, prácticas y políticas seleccionados debían cumplir al menos uno de los siguientes criterios: a) demostración del impacto en el suicidio mediante metanálisis o revisiones sistemáticas; b) evidencia de efectos preventivos significantes en el suicidio a partir de al menos un estudio de evaluación riguroso (por ejemplo, un estudio de diseño aleatorizado controlado o cuasiexperimental); c) demostración del efecto en los factores de riesgo de suicidio o de protección contra el suicidio mediante metanálisis o revisiones sistemáticas; o d) evidencia

de efecto en los factores de riesgo de suicidio o de protección contra el suicidio de al menos un estudio de evaluación riguroso (por ejemplo, un estudio de diseño aleatorizado controlado o cuasiexperimental). Por último, otros factores que se tuvieron en cuenta fueron la probabilidad de que se lograran efectos beneficiosos sobre varias formas de violencia; que no hubiera evidencia de efectos dañinos sobre determinados resultados ni con determinados subgrupos; y que la implementación fuera viable en el contexto de los Estados Unidos si el programa, política o práctica había sido evaluado en otro país.

Algunos de los enfoques incluidos en este paquete técnico todavía no cuentan con evidencia científica que demuestre su efecto en las tasas de suicidio, pero se sustentan en evidencia indicativa de su efecto en los factores de riesgo de suicidio o de protección contra el suicidio (por ejemplo, búsqueda de ayuda, reducción del estigma, depresión, conexión). En términos de la solidez de la evidencia, los programas que tienen efectos demostrados sobre los comportamientos suicidas (por ejemplo, reducción en la cantidad de muertes, intentos) proporcionan un más alto nivel de evidencia; sin embargo, la base de evidencia no tiene igual solidez en todas las áreas. Por ejemplo, ha habido una menor cantidad de evaluación en cuanto a la participación de la comunidad y los programas familiares sobre los comportamientos suicidas. Por lo tanto, los enfoques que se incluyen en este paquete y que tienen efectos sobre los factores de riesgo o de protección reflejan la naturaleza evolutiva de la base de evidencia y el uso de la mejor evidencia disponible en un momento dado.

Asimismo, es importante notar que es común que haya una significativa heterogeneidad entre los programas, las políticas y las prácticas que se encuentran bajo una misma estrategia o enfoque, en términos de la naturaleza y calidad de la evidencia disponible. No todos los programas, políticas o prácticas que usan el mismo enfoque tienen la misma eficacia, e incluso aquellos que sí son eficaces podrían no funcionar con todas las poblaciones. Para abordar los distintos grupos poblacionales podría ser necesario adaptar los programas o llevar a cabo más evaluaciones. El objetivo de incluir estos programas, prácticas y políticas basados en la evidencia en este paquete no es el de proporcionar una lista integral para cada enfoque, sino el de proporcionar ejemplos que han demostrado tener un impacto sobre el suicidio, o un efecto beneficioso sobre los factores de riesgo de suicidio o los factores de protección contra el suicidio.



Temas contextuales y que afectan a muchas áreas

Una importante característica de este paquete es el efecto complementario y potencialmente sinérgico que pueden tener las estrategias y los enfoques incluidos. Estas estrategias y enfoques abarcan distintos niveles de la ecología social, e incluyen esfuerzos que tienen el objetivo de influenciar tanto los niveles comunitario y social como los niveles individual y relacional, y deben actuar de manera combinada y como refuerzo uno del otro a fin de prevenir el suicidio (ver el recuadro en la página 12). Las estrategias aparecen en determinado orden; se incluyeron primero las que se hipotetizó que tendrán el mayor potencial de impacto en el suicidio en términos de salud pública general, seguidas de aquellas que podrían afectar a subgrupos poblacionales (por ejemplo, las personas que ya han tenido un intento de suicidio).

Prevención del suicidio

Estrategia	Enfoque
Fortalecimiento de los apoyos económicos	• Fortalecimiento de la seguridad financiera del hogar • Políticas para la estabilidad de vivienda
Fortalecimiento del acceso a los cuidados relacionados con el suicidio y de su prestación	• Cobertura de afecciones mentales en las pólizas de seguro médico • Reducción de la escasez de proveedores en las áreas subatendidas • Cuidados más seguros con relación al suicidio mediante cambios a nivel de sistema
Creación de ambientes protectores	• Reducción del acceso a medios letales entre las personas en riesgo de suicidio • Políticas y cultura a nivel de organización • Políticas comunitarias para la reducción del consumo excesivo de alcohol
Fomento de la conexión	• Programas de normas de semejantes • Actividades de participación en la comunidad
Enseñanza de destrezas de superación y resolución de problemas	• Programas de educación socio-emocional • Programas de destrezas de crianza y relaciones familiares
Identificación de las personas en riesgo y provisión de apoyo	• Capacitación del personal de primera línea • Intervención en crisis • Tratamiento para las personas en riesgo de suicidio • Tratamiento para la prevención de nuevos intentos
Reducción de los daños y prevención de riesgo futuro	• Intervención posterior • Informe y mensajes seguros en relación con el suicidio

Es importante notar que estas estrategias no son mutuamente excluyentes, sino que cada una tiene una área de concentración inmediata. Por ejemplo, los programas de educación socio-emocional, que son uno de los enfoques de la estrategia *Enseñanza de destrezas de superación y resolución de problemas*, a veces incluyen componentes centrados en cambiar las normas de los semejantes y el ambiente más extenso. Sin embargo, la concentración principal de estos programas es proporcionarles a los niños y adolescentes las destrezas para resolver los problemas en las relaciones, la escuela y con otros niños o adolescentes, y ayudarlos a abordar otras influencias negativas que se asocian con el suicidio (por ejemplo, el consumo de sustancias).

El objetivo de este paquete es poner de relieve la importancia de los esfuerzos integrales para la prevención y proporcionar ejemplos de programas eficaces que abordan cada nivel de la ecología social, con el conocimiento de que algunos programas, prácticas y políticas pueden tener efectos en varios niveles. Asimismo, aquellos que implican varios sectores y afectan varios niveles de la ecología social, tienen más probabilidades de tener un efecto mayor en la carga general del suicidio.

La ideación, los pensamientos, los intentos de suicidio y las muertes varían por género, raza u origen étnico, edad, ocupación y otras características poblacionales importantes.[6, 50] Asimismo, ciertos periodos de transición también se asocian a tasas más altas de suicidio (por ejemplo, la transición del trabajo a la jubilación, la transición del servicio militar activo a la vida civil).[48, 51] De hecho, el riesgo de suicidio puede cambiar junto a factores de riesgo dinámicos. Por ejemplo, la capacidad de superación que tiene una persona puede cambiar en los periodos de crisis y de mayor estrés, y limitar su capacidad normal para resolver problemas de modo eficaz y de superar la situación. Las investigaciones indican que la cantidad y la intensidad de los factores de riesgo y de protección clave que se experimenten causan cambios en el riesgo de suicidio.[52] Idealmente, lo recomendable es que haya disponibles múltiples estrategias y enfoques adaptados al contexto social, económico, cultural y ambiental de las personas y las comunidades, ya que podrían aumentar la probabilidad de eliminar las barreras que se interponen a una atención eficaz y de apoyo, y proporcionan oportunidades para desarrollar la resiliencia de las personas y las comunidades.[1]

La identificación de los programas, prácticas y políticas con evidencia de tener efecto sobre el suicidio o intentos de suicidio, o de tener efectos beneficiosos sobre los factores de riesgo de suicidio o de protección contra el suicidio es solamente el primer paso. En la práctica, la eficacia de los programas, prácticas y políticas identificados en este paquete dependerá poderosamente de qué tan bien se implementen y también de las organizaciones aliadas y las comunidades donde se implementen. Los profesionales en el campo podrían estar en la mejor posición para evaluar las necesidades y las fortalezas de sus comunidades y de trabajar con los miembros de la comunidad para tomar decisiones sobre la combinación de enfoques incluidos aquí que sean más propicios para su contexto.

Los procesos de planificación estratégica guiada por datos pueden ayudar a las comunidades con este trabajo.[5355] Estos procesos motivan y guían la participación de las partes interesadas de la comunidad mediante un proceso de planificación para la prevención diseñado para abordar el perfil de los factores de riesgo y de protección de la comunidad con programas, prácticas y políticas basados en la evidencia. Estos procesos también se pueden usar para monitorear la implementación de dichos programas, prácticas y políticas, hacer seguimiento de los resultados y hacer ajustes según indicado por los datos. El nivel de preparación que tenga el programa para una amplia difusión e implementación (por ejemplo, disponibilidad de materiales del programa, capacitación y asistencia técnica) también puede influir en su efecto. Las directrices para asistir a los médicos, las organizaciones y las comunidades con la implementación se elaborarán por separado.

Este paquete incluye estrategias para los sitios donde las agencias de salud pública estén bien posicionadas para hacer llegar liderazgo y recursos a los esfuerzos de implementación. También incluye estrategias para los sitios donde la salud pública pueda actuar como una importante colaboradora (por ejemplo, estrategias que aborden los niveles de riesgo comunitarios y sociales), pero donde el liderazgo y el compromiso de otros sectores (como el sector comercial, laboral o de atención médica) sea crítico para la implementación de un programa o política en particular (por ejemplo, las políticas en el lugar de trabajo, el tratamiento para prevenir los nuevos intentos de suicidio). La función de diversos sectores en la implementación de una estrategia o enfoque para la prevención del suicidio se describe en mayor profundidad en la sección *Participación de los sectores.*

En las secciones que siguen se describen las estrategias y los enfoques que cuentan con la mejor evidencia disponible para prevenir el suicidio.



Fortalecimiento de los apoyos económicos

Fundamento

Los estudios de los Estados Unidos que examinan las tendencias históricas indican que las tasas de suicidio aumentan en los tiempos de recesión económica marcados por altas tasas de desempleo, pérdida de trabajo e inestabilidad económica, y que descienden en los tiempos de expansión económica y los periodos marcados por bajas tasas de desempleo, particularmente entre las personas en edad laboral de entre 25 y 64 años de edad.[56,57] Las presiones económicas y financieras—como la pérdida del trabajo, periodos prolongados de desempleo, ingresos reducidos, dificultad para cubrir gastos médicos, alimentarios y de vivienda, e incluso, la anticipación de tales presiones financieras—pueden aumentar el riesgo de suicidio de las personas, así como también aumentarlo de manera indirecta al exacerbar los problemas físicos y mentales relacionados.[58] El amortiguamiento de estos riesgos puede, por lo tanto, potencialmente protegerlas contra el suicidio. Por ejemplo, al fortalecer los sistemas de apoyo económico se las puede ayudar a permanecer en su hogar o conseguir vivienda asequible y, a la vez, pagar por las necesidades de la vida diaria, como los alimentos, la atención médica, la capacitación laboral y el cuidado de niños. Este apoyo puede reducir el estrés y la ansiedad, y el potencial de una situación de crisis y, por consiguiente, prevenir el suicidio. Aunque se necesita mucha más investigación para comprender la forma en que los factores económicos interactúan con otros factores para aumentar el riesgo de suicidio, la evidencia disponible sugiere que el fortalecimiento de los apoyos económicos puede ser una oportunidad de amortiguar el riesgo de suicidio.

Enfoques

Se pueden fortalecer los apoyos económicos de las personas y las familias al enfocarse en la seguridad financiera del hogar y asegurar su estabilidad de vivienda en los tiempos de estrés económico.

Fortalecimiento de la seguridad financiera del hogar. Este enfoque puede potencialmente amortiguar el riesgo de suicidio al proporcionarles a las personas los medios financieros para reducir la dificultad económica y el estrés relacionados con la pérdida del trabajo o con otros problemas financieros no anticipados. Proporcionar beneficios por desempleo y otras formas de asistencia temporaria, salarios dignos, beneficios médicos, y jubilación y seguro por discapacidad para ayudar a cubrir el costo de las necesidades o para contrarrestar los costos en caso de discapacidad, son ejemplos de formas de fortalecer la seguridad financiera del hogar.

Políticas para la estabilidad de vivienda. Estas políticas tienen el objetivo de ayudar a las personas a permanecer en su hogar y de proporcionarles opciones de vivienda a aquellas que lo necesiten en tiempos de inseguridad financiera. Esto puede suceder por medio de programas de vivienda asequible (por ejemplo, a través de subsidios gubernamentales) o de otras opciones disponibles para quienes puedan comprar un hogar (como programas de modificación de préstamos, servicios de planificación de mudanza o de asesoramiento financiero), que ayuden a reducir al mínimo el riesgo o el impacto de las ejecuciones hipotecarias y los desalojos.

Resultados potenciales

- Reducción en las tasas de ejecuciones hipotecarias
- Reducción en las tasas de desalojos
- Reducción en el sufrimiento emocional
- Reducción en las tasas de suicidio

Evidencia

Hay evidencia que sugiere que el fortalecimiento de la seguridad financiera del hogar y la estabilidad de vivienda pueden reducir el riesgo de suicidio.



Fortalecimiento de la seguridad financiera del hogar. El *Programa de Seguro por Desempleo Federal y Estatal* permite que los estados definan la cantidad y la duración máxima de los beneficios por desempleo que los trabajadores tienen derecho de percibir tras la pérdida del trabajo.[59] Un análisis de las variaciones existentes en los *programas de beneficios por desempleo* de todos los estados demostró que en los estados que proporcionaban beneficios por desempleo mayores al promedio (mediana: 7990 dólares por persona en dólares estadounidenses ajustados por inflación) se había contrarrestado el impacto del desempleo en las tasas de suicidio. Los efectos de los *programas de beneficios por desempleo* también fueron uniformes en términos de sexo y grupo etario.[59] En otro estudio en los Estados Unidos se examinó el vínculo existente entre el desempleo y las tasas de suicidio usando datos mensuales sobre el suicidio, la duración del desempleo (menos de 5 semanas, 5-14 semanas, 15-26 semanas y más de 26 semanas) y la pérdida de trabajo, y se halló que la duración del desempleo, en contraste con solamente la pérdida del trabajo, predecía el riesgo de suicidio.[60] Agrupados, estos resultados parecen indicar que los programas de beneficios por desempleo estatales deben ser generosos no solo en cuanto a sus asignaciones financieras sino también a su duración.

Otras medidas que fortalecen la seguridad financiera del hogar (por ejemplo, las asignaciones relativas a la jubilación y al seguro por discapacidad, la compensación de seguro por desempleo, los beneficios médicos y otras formas de asistencia para las familias) también han demostrado influir en las tasas de suicidio. En un estudio realizado por Flavin y Radcliff[61] se examinó el efecto que tuvieron los gastos per cápita de los estados para tales asignaciones, beneficios médicos y asistencia a las familias (Asistencia Temporal para Familias Necesitadas o TANF, por sus siglas en inglés) y sus gastos totales sobre las tasas de suicidio durante el periodo 1999-2000, haciendo ajustes por la cantidad de factores de riesgo de suicidio (por ejemplo, movilidad residencial, tasas de divorcio, tasas de desempleo) a nivel de estado. A medida que aumentaron los gastos per cápita totales por asignaciones, beneficios médicos y asistencia para las familias hubo un descenso asociado en las tasas de suicidio de los estados. En términos de vidas salvadas, Flavin y Radcliff calcularon el costo de reducir



las tasas de suicidio de un estado por un punto entero para los años estudiados.[61] A nivel nacional, estimaron que ocurrirían 3000 suicidios menos al año si cada estado aumentara 45 dólares al año el gasto per cápita para estos tipos de asignaciones asistenciales.[61] Aunque este fue un estudio correlacional, los resultados demuestran los potenciales beneficios de las políticas que llegan particularmente a las personas más vulnerables en los momentos de mucha necesidad. Se necesita hacer más estudios de evaluación para entender en mayor profundidad el efecto que estos tipos de programas tienen en los resultados.

Políticas para la estabilidad de vivienda. El *Programa de Estabilización Vecinal (Neighborhood Stabilization Program)*[62] fue diseñado para ayudar a los vecindarios que estuvieran sufriendo altas tasas de ejecución hipotecaria y abandono, al desacelerar el deterioro de los vecindarios y proporcionarles opciones de vivienda asequibles a aquellas personas con ingresos bajos, moderados o medios que fueran a comprar. Este programa también ofrece asistencia financiera para la compra de casa nueva a las personas elegibles. Aunque este programa no se ha evaluado rigurosamente en términos de su efecto en los resultados relacionados con el suicidio, aborda las ejecuciones hipotecarias y los desalojos, que son factores de riesgo de suicidio. Un análisis longitudinal sobre los datos anuales relacionados con el suicidio y las ejecuciones hipotecarias mostró que a medida que aumentaba la proporción de propiedades sujetas a ejecución hipotecaria en los Estados Unidos, también aumentaba la tasa de suicidio, particularmente entre los adultos de edad laboral.[63] Otro estudio realizado a partir de los datos provenientes de 16 estados de los Estados Unidos que participan en el *Sistema Nacional de Notificación de Muertes Violentas* halló que la cantidad de suicidios precipitados por ejecuciones hipotecarias y desalojos aumentó más del 100 % entre el 2005 (antes de que comenzara la crisis de vivienda) y el 2010 (después de su punto máximo).[57] La mayoría de estos suicidios ocurrió antes de que la persona muerta perdiera efectivamente la casa. Estos hallazgos parecen indicar que si se integran recursos, mensajes y remisiones para la prevención del suicidio a los servicios de planificación y asesoramiento financieros, hipotecarios y de mudanza, esto podría ayudar a prevenir suicidios.



Fortalecimiento del acceso a los cuidados relacionados con el suicidio y de su prestación

Fundamento

Si bien la mayoría de las personas con problemas de salud mental no intentan suicidarse ni mueren por suicidio[18, 19] y el nivel de riesgo conferido por distintos tipos de enfermedad mental varía,[64-66] en investigaciones anteriores se indica que la enfermedad mental es un factor de riesgo importante de suicidio.[5, 67] También se ha hallado que las tasas de suicidio a nivel estatal se correlacionan con medidas de salud mental generales, como la depresión.[68, 69] Los hallazgos derivados de la *Encuesta Nacional sobre Comorbilidad* indican que una cantidad relativamente baja de personas en los Estados Unidos con trastornos de enfermedad mental recibe tratamiento para tales afecciones.[70] La falta de acceso a la atención de salud mental es uno de los factores contribuyentes relacionados con el uso insuficiente de servicios de salud mental.[71] Uno de los componentes esenciales de la prevención es identificar las maneras de mejorar el acceso de las personas que lo necesitan a la atención de salud mental y a cuidados relativos al suicidio oportunos, asequibles y de calidad.[5] Además, las investigaciones parecen indicar un máximo aprovechamiento de los servicios provistos cuando los sistemas de atención médica y de salud mental están organizados de manera tal, que la atención se presta efectiva y eficazmente.[72] Aparte de los beneficios del tratamiento, estos enfoques también pueden normalizar el comportamiento de búsqueda de ayuda y aumentar el uso de estos servicios.

Enfoques

Hay varios enfoques que se pueden usar para fortalecer el acceso a los cuidados relacionados con el suicidio y la prestación de estos, incluidos:

Cobertura de afecciones mentales en las pólizas de seguro médico. Las leyes federales y estatales incluyen disposiciones que establecen igual cobertura para los servicios de salud mental en los planes de seguro médico que para las demás preocupaciones de salud (es decir, paridad en la salud mental).[73] Los beneficios y servicios cubiertos incluyen ciertas características, como cantidad de visitas, copagos, deducibles, servicios ambulatorios y hospitalarios, medicamentos recetados y hospitalizaciones. Si un estado tiene una ley de paridad de salud mental más fuerte que la federal, entonces los planes de seguro regulados por el estado deben seguir la ley de paridad del estado. Si un estado tiene una ley de paridad menos fuerte que la federal (por ejemplo, incluye cobertura para algunas afecciones mentales pero no para otras), entonces la ley de paridad federal prevalecerá sobre la del estado. Ofrecer igual cobertura no necesariamente implica ofrecer buena cobertura, ya que la extensión de los servicios y beneficios que ofrecen los planes de seguro médico para abordar distintas afecciones varía. Sin embargo, ayuda a asegurar que los servicios de salud mental estén cubiertos a la par de otras preocupaciones de salud.

Reducción de la escasez de proveedores en las áreas subatendidas. El acceso a atención médica de salud mental eficaz y de avanzada depende en gran parte de la capacitación y el tamaño de su fuerza laboral. Más de 85 millones de personas en los Estados Unidos viven en áreas en las que no hay suficientes proveedores de salud mental; esta escasez es particularmente marcada en las comunidades urbanas de bajos ingresos y las comunidades rurales.[74] Hay varias formas de aumentar la cantidad y la distribución de los proveedores de salud mental que ejercen en las áreas subatendidas. Estas incluyen ofrecerles incentivos financieros a través de los programas estatales y federales existentes (por ejemplo, programas de amortización de préstamos) y ampliar el alcance de los servicios de salud a través del uso de tecnologías de telefonía, video e internet. Tales enfoques aumentarían la probabilidad de que las personas que la necesiten puedan acceder a atención médica asequible y de calidad para los problemas de salud mental, lo cual puede reducir el riesgo de suicidio.

Cuidados más seguros con relación al suicidio mediante cambios a nivel de sistema El acceso a servicios de atención médica y de salud mental es esencial para las personas en riesgo de suicidio; sin embargo, es solamente uno de los componentes de la prevención. La atención debe también ser prestada de manera eficiente y eficaz. Más específicamente, debe prestarse dentro de un sistema que apoye la prevención del suicidio y la seguridad del paciente a través de un sólido liderazgo, la capacitación de la fuerza laboral, la identificación y evaluación sistemática del riesgo de suicidio, la implementación de tratamientos basados en la evidencia (ver *Identificación de las personas en riesgo y provisión de apoyo*), la continuidad de la atención y el mejoramiento continuo de la calidad. El cuidado que esté centrado en el paciente y que promueva la equidad para todos los pacientes es, además, de crítica importancia.[75]

Resultados potenciales

- Mayor uso de los servicios de salud mental
- Menores tasas de abandono del tratamiento
- Reducción de los síntomas depresivos
- Reducción en las tasas de intento de suicidio
- Reducción en las tasas de suicidio

Evidencia

Hay evidencia que sugiere que la cobertura de las afecciones de salud mental en las pólizas de seguro médico y mejorar el acceso a los servicios y la prestación de estos puede reducir los factores asociados al suicidio y tener un efecto directo en las tasas de suicidio.

Cobertura de afecciones mentales en las pólizas de seguro médico. *La Encuesta Nacional sobre el Consumo de Drogas y la Salud (NSDUH)* es una encuesta representativa a nivel nacional de la población de los Estados Unidos que proporciona datos sobre el consumo de sustancias, afecciones de salud mental y utilización de servicios.[50] Con los datos de esta encuesta, Harris, Carpenter y Bao[76] encontraron que 12 meses después de que los estados promulgaran las *leyes de paridad de salud mental*, aumentó significativamente el uso autorreportado de servicios de salud mental. Más aún, la investigación subsiguiente realizada por Lang[69] examinó la relación entre las leyes estatales de salud mental y las tasas de suicidio desde 1990 hasta el 2004, y encontró que las leyes de paridad de salud mental se asociaron, específicamente, a una reducción aproximada del 5 % en las tasas de suicidio. Esta reducción se tradujo, en los 29 estados con leyes de paridad, en la prevención de 592 suicidios al año.[69]

Reducción de la escasez de proveedores en las áreas subatendidas. Un ejemplo de un programa para mejorar el acceso a proveedores de salud mental es el *Cuerpo Nacional de Salud (NHSC, por sus siglas en inglés)*, que ofrece incentivos financieros para atraer a médicos de salud mental o del comportamiento hacia las áreas subatendidas.[77] Los programas como este animan a las personas a trabajar en profesiones de salud mental en sitios designados como "áreas de escasez de profesionales de salud" (HPSA, por sus siglas en inglés) a cambio de la amortización de sus préstamos estudiantiles. Una encuesta sobre la retención de estos profesionales realizada por la Administración de Recursos y Servicios de Salud (HRSA, por sus siglas en inglés) halló que el 61 % de ellos seguía trabajando en áreas de escasez designadas después de su compromiso de 4 años con el *NHSC*.[78] A pesar de que este programa no ha sido evaluado en términos del efecto que tiene sobre el suicidio, aborda el acceso a la atención médica, el cual es un componente esencial de la prevención del suicidio.

Los servicios de *telesalud mental (TMH, por sus siglas en inglés)* son servicios de atención sicológica y siquiátrica a distancia que se prestan mediante el uso de tecnologías de telefonía, video e Internet.[79] Este tipo de servicio se puede usar en una variedad de entornos (por ejemplo, centros médicos ambulatorios, hospitales, establecimientos de tratamiento militares) para tratar una amplia variedad de afecciones mentales. También puede mejorar el acceso de los pacientes que están en áreas aisladas y su satisfacción con la interacción con el sistema de salud mental, y reducir tanto sus gastos y tiempo de transporte como las demoras para la prestación de la atención médica. Una revisión sistemática de los servicios de



TMH halló que los que fueron calificados como servicios de alta o buena calidad fueron eficaces para el tratamiento de afecciones mentales como la depresión, la esquizofrenia, el abuso de sustancias, y el suicidio y la ideación suicida.[79] Además, Mohr y colegas[80] hicieron un metanálisis para examinar el efecto de la sicoterapia telefónica, en particular, y hallaron que este tipo de terapia redujo significativamente los síntomas depresivos en comparación con la terapia cara a cara. También hallaron que las tasas de abandono del tratamiento fueron significativamente más bajas entre los pacientes que recibían la sicoterapia administrada telefónicamente que entre aquellos que la recibían cara a cara.[80] Por lo tanto, los servicios de TMH quizás no solo ofrezcan mejor acceso a atención de salud mental sino que también podrían asegurar continuidad en el tratamiento y, por consiguiente, una mayor reducción en el riesgo de suicidio.

Cuidados más seguros con relación al suicidio mediante cambios a nivel de sistema. El *Sistema de Salud Henry Ford*, que es una organización de mantenimiento de la salud (HMO, por sus siglas en inglés) en el estado de Michigan, lideró la iniciativa *Atención Perfecta de la Depresión (Perfect Depression Care)*,[81] que es la precursora de lo que ahora se llama *Cero Suicidios (Zero Suicide)*. La meta general de *Atención Perfecta de la Depresión* era eliminar el suicidio entre los miembros de la HMO. En términos más amplios, la meta del programa era rediseñar la forma en que se prestaba la atención médica para la depresión y enfocarse en que fuera eficaz, segura, centrada en el paciente, oportuna, eficiente y equitativa entre los pacientes a fin de lograr una "mejora notable" en su calidad y seguridad. El programa evaluaba y determinaba el riesgo de suicidio de cada paciente e implementaba atención de seguimiento coordinada y continua a nivel de sistema.[81] Al examinar el efecto del programa se halló que hubo un descenso drástico y estadísticamente significativo en las tasas de suicidio entre el inicio (1999 y el 2000) y el periodo de intervención (2002-2009). Durante ese tiempo, las tasas de suicidio descendieron un 82 %.[81, 82] Asimismo, entre los miembros de la HMO que recibieron los servicios de especialidad de salud mental, la tasa de suicidio se redujo significativamente a lo largo del tiempo, desde 1999 al 2010 (de 110.3 a 47.6 por cada 100 000 personas; $p<0.04$), con una mediana de 36.2 por cada 100 000 personas durante ese periodo.[83] Además, para los miembros de la HMO que habían accedido solamente a servicios médicos en general, y no a servicios de especialidad de salud mental, la tasa de suicidio aumentó de 2.7 a 5.6 por cada 100 000 personas ($p<0.01$).[83] De manera similar, en el estado de Michigan, las tasas de suicidio de la población general aumentaron de 9.8 a 12.5 por cada 100 000 personas ($p<0.001$) durante ese periodo.[83]



Creación de ambientes protectores

Fundamento

Los esfuerzos de prevención que no solo se enfocan en los cambios de comportamiento individuales (por ejemplo, buscar ayuda, intervenciones de tratamiento) sino también en cambios en el ambiente pueden aumentar la probabilidad de que se consigan resultados positivos de salud y comportamiento.[84] La creación de ambientes que aborden los factores de riesgo y de protección en los lugares donde las personas viven, trabajan y se entretienen puede ayudar a prevenir el suicidio.[1, 17] Por ejemplo, las tasas de suicidio son altas entre los adultos de mediana edad que forman parte del 42.6 % de la fuerza laboral;[85] ciertos grupos ocupacionales;[10, 11] y las personas que están en centros de detención (por ejemplo, prisión, cárcel),[86] entre otros. Por lo tanto, los entornos donde residen y trabajan estas poblaciones son ideales para implementar programas, prácticas y políticas que actúen como amortiguadores contra el suicidio. Si se hacen cambios en la cultura de una organización mediante, por ejemplo, la implementación de políticas de apoyo, se pueden cambiar las normas sociales, se puede animar a las personas a buscar ayuda y se puede demostrar que se valora la buena salud y la buena salud mental, y no el estigma ni los demás factores de riesgo de suicidio.[87, 88] De manera similar, si para prevenir los comportamientos dañinos se modifican las características del ambiente físico como, por ejemplo, el acceso a medios letales, se pueden reducir las tasas de suicidio, particularmente en tiempos de crisis o transición.[89-94]

Enfoques

Según la evidencia actual, se proponen tres posibles enfoques para la creación de ambientes que protejan contra el suicidio.

Reducción del acceso a medios letales entre las personas en riesgo de suicidio. Los medios de suicidio como el uso de armas de fuego, colgarse o sofocarse, o saltar de un lugar alto, no proporcionan mucha oportunidad de rescate y, por lo tanto, tienen como resultado tasas altas de muerte (por ejemplo, aproximadamente el 85 % de las personas que usan una arma de fuego en un intento de suicidio mueren por la lesión).[95] Las investigaciones, además, parecen indicar que: 1) el intervalo de tiempo entre el momento de la decisión de actuar y el intento de suicidio puede ser tan corto como 5-10 minutos,[96, 97] y 2) las personas tienden a *no* sustituir los métodos altamente letales por otros, cuando estos no están disponibles o son de difícil acceso.[98, 99] Por lo tanto, aumentar el intervalo de tiempo entre la decisión de actuar y el intento de suicidio (por ejemplo, al hacer que sea más difícil acceder a medios letales) puede salvar vidas. Los siguientes son ejemplos de enfoques que reducen el acceso a medios letales de las personas en riesgo de suicidio:

- *Intervenciones en lugares propicios para el suicidio.* Los lugares propicios para el suicidio, o lugares donde pueden materializarse los suicidios con relativa facilidad, incluyen los lugares altos (por ejemplo, precipicios, balcones y techos), las vías del tren y los lugares aislados, como los parques. Los esfuerzos para prevenir el suicidio en estos lugares incluyen colocar barreras o limitar el acceso a ellos para evitar que las personas salten, e instalar carteles y teléfonos para animar a las que estén considerando suicidarse a solicitar ayuda.[100]
- *Prácticas de almacenamiento seguro.* Tener los medicamentos, las armas de fuego y otros productos domésticos guardados en un lugar seguro puede reducir el riesgo de suicidio al crear una separación entre las personas vulnerables y el fácil acceso a medios letales. Dichas prácticas podrían incluir educación y consejería en torno al almacenamiento de las armas de fuego bajo llave en un lugar seguro (por ejemplo, en una caja fuerte o una caja de seguridad para armas), no cargadas y por separado de las municiones; y al mantenimiento de los medicamentos en un armario bajo llave o en otro lugar seguro alejado de las personas que podrían estar en riesgo o que hayan intentado suicidarse anteriormente.[89,101]

Políticas y cultura a nivel de organización. Se podrían implementar políticas y una cultura que fomenten un ambiente de protección en los lugares de trabajo, los centros de detención y otros entornos seguros (por ejemplo, los entornos residenciales). Dichas políticas y valores culturales animan al liderazgo de arriba hacia abajo y podrían promover comportamientos prosociales (por ejemplo, pedir ayuda), el desarrollo de destrezas, normas sociales positivas, evaluaciones, remisiones y acceso a servicios de asistencia (por ejemplo, salud mental, tratamiento de abuso de sustancias, consejería financiera), así como también la creación de planes de respuesta ante crisis, intervenciones posteriores y otras medidas para fomentar un ambiente físico seguro. Estos ajustes en las políticas y la cultura pueden tener un impacto positivo en el clima y la moral de la organización, y ayudar a prevenir el suicidio y los factores de riesgo relacionados (por ejemplo, la depresión, el aislamiento social).[88, 102]

Políticas comunitarias para la reducción del consumo excesivo de alcohol. Se ha hallado en estudios de investigación en los Estados Unidos que hay una asociación fehaciente entre la mayor disponibilidad de alcohol y los suicidios en los que media el alcohol.[103-105] Las políticas para reducir extensamente el consumo excesivo de alcohol incluyen limitar la ubicación de los lugares que venden alcohol y su densidad geográfica, imponer impuestos sobre el alcohol y prohibir la de venta de alcohol a las personas que no tengan la edad legal para consumirlo.[105] Estas políticas son importantes porque se ha hallado que el consumo excesivo y rápido de alcohol se asocia a más de una tercera parte de los suicidios y a aproximadamente el 40 % de los intentos de suicidio.[106]



Resultados potenciales

- Mayor almacenamiento seguro de medios letales
- Reducción en las tasas de suicidio
- Reducción de los intentos de suicidio
- Aumento en la búsqueda de ayuda
- Reducción en las muertes por suicidio relacionadas con el alcohol

Evidencia

La evidencia sugiere que crear ambientes protectores puede reducir las tasas de suicido y de intentos de suicidio y aumentar la cantidad de comportamientos protectores.

Reducción del acceso a medios letales entre las personas en riesgo de suicidio. En un metanálisis en el que se examinó el efecto de las *intervenciones en lugares propicios para el suicidio*, ya sean implementadas de manera combinada o aislada, tanto en los Estados Unidos como en otros países, se halló que estas intervenciones se asociaban a menores tasas de suicidio.[100, 107] Por ejemplo, después de erguir una barrera en el puente Jacques-Cartier en Canadá, las tasas de suicidio por saltar de este puente se redujeron de aproximadamente 10 a 3 muertes por suicidio al año.[108] Asimismo, se mantuvo esta reducción en la cantidad de suicidios por saltar desde lugares altos incluso cuando se tuvieron en cuenta todos los puentes y lugares cercanos que se podían usar para este propósito, lo cual parece indicar que los suicidios no se transfirieron a otros lugares altos.[108] La eficacia del uso de barreras en los puentes quedó demostrada, además, en un estudio en el que se examinó el impacto que tuvo el *retiro* las barreras de seguridad del puente Grafton Bridge en Auckland, Nueva Zelanda. Luego de retirar las barreras se quintuplicaron tanto la cantidad como las tasas de suicidio.[93, 109]

Otra forma en que se pueden reducir los medios para el suicidio implica el uso de *prácticas de almacenamiento seguro*. En un estudio de casos y controles de eventos relacionados con el uso de armas de fuego identificados en 37 condados en Washington, Oregón y Misuri, y 5 centros de trauma, los investigadores hallaron que guardar las armas de fuego descargadas, separadas de las municiones, en un lugar bajo llave o con dispositivos de seguridad era una medida protectora contra los intentos de suicidio entre los adolescentes.[110] Además, una revisión sistemática reciente de las intervenciones de educación y consejería, tanto clínicas como comunitarias, parece indicar que el hecho de proporcionarles a las personas los dispositivos de seguridad para las armas de fuego aumentó significativamente la práctica de almacenarlas de manera segura en comparación con proporcionarles los incentivos económicos para que los compraran por su cuenta.[101]

Otro programa, llamado *Consejería en Sala de Emergencias sobre el Acceso a Medios Letales (Emergency Department Counseling on Access to Lethal Means, ED CALM)*, instruyó a los médicos de emergencias siquiátricas de un hospital de niños grande a proporcionarles consejería sobre los medios letales y las cajas de seguridad para armas a los padres de los menores de 18 años que estuvieran recibiendo atención médica por un comportamiento suicida. En un proyecto de mejora de la calidad previo y posterior a la consejería, Runyan et al[89] hallaron que al momento del ensayo posterior el 76 % de los padres (del 55 % de aquellos a los que se les hizo seguimiento, n=114) reportaron que todos los medicamentos

que habían en su casa estaban bajo llave, comparado con menos del 10 % al momento de la visita inicial a la sala de emergencias. Entre los padres que indicaron la presencia de armas en el hogar en el ensayo previo (o sea, el 67 %), todos (el 100 %) reportaron en el ensayo posterior que las armas estaban actualmente guardadas bajo llave.[89]

Políticas y cultura a nivel de organización. *Juntos por la Vida (Together for Life)* es un programa de la fuerza policial de Montreal que se implementó para abordar el suicidio entre los oficiales de policía. Las políticas y los componentes del programa tenían el objetivo de fomentar una cultura dentro de la organización que promoviera la solidaridad y el apoyo mutuo entre todos los miembros de la fuerza policial. El programa incluyó la capacitación de supervisores, gerentes y todas las unidades para mejorar sus competencias para identificar el riesgo de suicidio y aumentar la conciencia y el uso de los recursos existentes. También incluyó una campaña educativa para mejorar la conciencia y la búsqueda de ayuda.[111] Se hizo un seguimiento de los suicidios entre los policías a lo largo de 12 años y se compararon esas tasas con las de Quebec, que fue la cuidad de control. Las tasas de suicidio descendieron significativamente en el grupo de intervención (78.9 %) a una tasa de 6.4 suicidios por cada 100 000 personas al año, en comparación con un aumento del 11 % en la ciudad de control (29.0 por cada 100 000).[111]

Otro ejemplo de este enfoque es el *Programa de Prevención del Suicidio de la Fuerza Aérea de los Estados Unidos (United States Air Force Suicide Prevention Program)*. El programa incluyó 11 políticas e iniciativas educativas que tenían el objetivo de cambiar la cultura de la Fuerza Aérea en torno al suicidio. Este programa usa a líderes como ejemplos a seguir y agentes de cambio, establece expectativas de comportamiento en cuanto a tener conciencia sobre el riesgo de suicidio, desarrolla las destrezas y los conocimientos de esta población (o sea, mediante educación y capacitación) e investiga cada caso de suicidio (o sea, medición de los resultados). Asimismo, representa un cambio fundamental que implica ver al suicidio y a la enfermedad mental no solo como problemas médicos sino también como problemas más abarcadores de todas las fuerzas armadas, que afectan a toda la comunidad.[112] Mediante el uso de un diseño de estudio de series temporales para examinar el efecto del programa en varios criterios de valoración relacionados con la violencia, los investigadores hallaron que el programa se asoció con una reducción del 33 % en el riesgo relativo del suicidio.[112] El programa también se asoció con reducciones en el riesgo relativo de los criterios de valoración relacionados, incluidos la violencia moderada y grave en la familia (30 % y 54 %, respectivamente), el homicidio (51 %) y la muerte accidental (18 %).[112] En un análisis longitudinal del programa para el periodo desde 1981 hasta el 2008 (16 años antes de que se lanzara el programa en 1997, y 11 años después) se halló que las tasas de suicidio fueron significativamente más bajas después del lanzamiento del programa que antes de este.[87] Estos efectos fueron constantes a lo largo del tiempo, excepto en el 2004, año que los autores hallaron se asoció a una implementación menos rigurosa de los componentes del programa en comparación con los otros años.[87]

Por último, mientras todavía se está formando la evidencia para la prevención del suicidio en las instalaciones correccionales, la evidencia preliminar parece indicar que se pueden potencialmente reducir las tasas de suicidio mediante políticas y prácticas a nivel de organización que incluyan capacitación rutinaria en la prevención del suicidio para todo el personal; evaluaciones de ingreso y de riesgo estandarizadas; la provisión de información compartida entre los miembros del personal (especialmente en las transiciones y los traslados de los reclusos); diversos niveles de observación; ambientes físicos seguros; protocolos de respuesta ante emergencias; la notificación de comportamientos suicidas/suicidios en toda la cadena de mando; el uso de la técnica de intervención de apoyo tras incidentes críticos y análisis de muertes (*critical incident stress debriefing and death review*).[102] Cuando se implementaron estas políticas y prácticas en 11 prisiones de Luisiana, las tasas de suicidio se redujeron en un 46 % (de una tasa de 23.1 por cada 100 000 personas antes de la intervención a una de 12.4 por cada 100 000 personas al año siguiente).[113] Otros programas similares han mostrado reducciones en las tasas de suicidio, tanto en los Estados Unidos como en otros países .[114]

Políticas comunitarias para la reducción del consumo excesivo de alcohol. Si bien existen varias políticas para limitar el consumo de alcohol en exceso, hay varios estudios sobre la relación entre la densidad geográfica de lugares de venta de alcohol y los factores de riesgo de suicidio (como violencia interpersonal y conexión social), [115-118] que sugieren que las medidas para reducir la densidad geográfica de lugares de venta de alcohol podrían potencialmente reducir la cantidad de suicidios en los que medie el alcohol. Asimismo, un análisis longitudinal sobre la densidad geográfica de lugares de venta de alcohol, la mortalidad por suicidio y las hospitalizaciones por intento de suicidio en un periodo de 6 años en el área de 581 códigos postales de California indicó que las densidades mayores de bares, específicamente, se relacionaron con mayores cantidades de suicidios e intentos de suicidio, en especial en las áreas rurales.[119]



Fomento de la conexión

Fundamento

La socióloga Emile Durkheim planteó la teoría en 1897 de que una de las causas principales del riesgo de suicidio era tener vínculos sociales débiles; o sea, falta de conexión.[120] La conexión es el grado al que una persona o grupo de personas tienen cercanía social, se interrelacionan o comparten recursos con los demás.[121] Las conexiones sociales se pueden formar dentro los distintos niveles de la ecología social y entre estos niveles;[17] por ejemplo, entre personas (semejantes, vecinos, compañeros de trabajo), familias, escuelas, vecindarios, lugares de trabajo, comunidades religiosas, grupos culturales y la sociedad en su totalidad. Dentro del contexto de esta conexión, el término capital social se refiere al sentido de confianza que una persona tiene en su comunidad o vecindario, su integración social y también a la disponibilidad de organizaciones sociales y a su participación en ellas.[122, 123] En muchos estudios ecológicos transversales y longitudinales se ha examinado el efecto que tienen los aspectos del capital social en los síntomas de la depresión, el trastorno depresivo, la salud mental en general y el suicidio. Si bien la evidencia es limitada, los estudios existentes parecen indicar que hay una asociación positiva entre el capital social (medido a partir de la confianza social y la participación comunitaria y vecinal) y tener mejor salud mental.[124, 125] Juntos la conexión y el capital social pueden proteger contra los comportamientos suicidas al reducir el aislamiento, animar la adopción de comportamientos de superación adaptativos y al aumentar el grado de pertenencia, valor personal y valoración, para ayudar a desarrollar resiliencia ante la adversidad. El grado de conexión puede también proporcionar a las personas un mejor acceso a recursos y apoyos formales, movilizar a las comunidades a satisfacer las necesidades de sus integrantes y proporcionar actividades colectivas de prevención primaria a la comunidad en su totalidad.[121]

Enfoques

Al modelar las normas de los semejantes y mejorar la participación comunitaria para fomentar la conexión entre las personas y dentro de las comunidades puede proteger contra el suicidio.

Programas de normas de semejantes. Estos programas tienen el objetivo de normalizar los factores de protección contra el suicidio, como buscar ayuda, acercarse y hablar con un adulto de confianza y promover la conexión con semejantes. Al aprovechar las cualidades de liderazgo y la influencia social de los semejantes, estos enfoques se pueden usar para modificar las creencias a nivel de grupo y promover un cambio positivo a nivel social y comportamental. Estos enfoques generalmente están dirigidos a los jóvenes y se implementan en entornos escolares, pero también se pueden implementar en entornos comunitarios.[126]

Actividades de participación en la comunidad. La participación en la comunidad es uno de los aspectos del capital social.[127] Los enfoques para la participación en la comunidad pueden implicar la participación de las personas en una variedad de actividades, incluidas las actividades religiosas, las actividades de limpieza y enverdecimiento *(greening)* y las actividades grupales de ejercicio físico. Estas actividades les proporcionan la oportunidad de tener mayor participación en la comunidad y de conectarse con otros integrantes de la comunidad, organizaciones y recursos, lo cual lleva a una mejor salud física general, menos estrés y menos síntomas depresivos que, a su vez, reducen el riesgo de suicidio.

Resultados potenciales

- Aumento en las actitudes y los comportamientos saludables de superación
- Aumento en las remisiones de jóvenes que están sufriendo
- Aumento en la búsqueda de ayuda
- Aumento en la percepción sobre el apoyo de los adultos



Evidencia

La evidencia actual sugiere que las actividades de normas de semejantes y la participación en la comunidad presentan un número de beneficios positivos, aunque se necesitan hacer más investigaciones de evaluación para examinar si estas mejoras respecto de los factores de protección contra los comportamientos suicidas se traducen en una cantidad menor de intentos de suicidio y muertes por suicidio.

Programas de normas de semejantes. Las evaluaciones muestran que los programas como *Fuentes de Fortaleza (Sources of Strength)* pueden mejorar las normas y las creencias que los estudiantes crean y difunden sobre el suicidio en las escuelas. En un estudio controlado aleatorizado sobre el programa *Fuentes de Fortaleza* que se realizó con 18 escuelas secundarias superiores (6 metropolitanas, 12 rurales), los investigadores hallaron que el programa mejoró las normas adaptativas relativas al suicidio, la conexión con los adultos y la participación escolar.[36] Los líderes semejantes también tuvieron mayor propensión a remitir a sus amigos suicidas a un adulto que los del grupo de control. El resultado del programa para los estudiantes fue una mayor percepción de apoyo de los adultos a los jóvenes suicidas, particularmente entre aquellos que tenían antecedentes de ideación suicida, y la aceptabilidad de los comportamientos de búsqueda de ayuda. Por último, los líderes semejantes capacitados también reportaron una mayor reducción en las actitudes de inadaptación respecto de la superación, en comparación con los no capacitados.[36]



Actividades de participación en la comunidad. En Filadelfia se realizó una iniciativa de enverdecimiento de lotes vacantes entre 1999 y el 2008. Los residentes locales y miembros de la comunidad trabajaron juntos para limpiar, enverdecer y mantener 4436 lotes (o 7.8 millones de pies cuadrados) en cuatro áreas de la ciudad. Los investigadores hallaron reducciones significativas en los niveles de estrés autorreportados de los residentes, que es uno de los factores de riesgo de suicidio, y mayor actividad física, que es uno de los factores de protección contra el suicidio, que en los residentes de las áreas de lotes vacantes de control. Hay algo de evidencia de beneficios en otras áreas, como reducciones en la cantidad de asaltos a mano armada y vandalismo.[128, 129]



Enseñanza de destrezas de superación y resolución de problemas

Fundamento

El desarrollo de destrezas de la vida diaria, prepara a las personas para afrontar exitosamente los desafíos de la vida diaria y para adaptarse al estrés y la adversidad. El concepto general de destrezas de la vida diaria abarca a varios conceptos, pero suele incluir destrezas de superación y resolución de problemas, regulación emocional, resolución de conflictos y pensamiento crítico. Las destrezas de la vida diaria son importantes para proteger a las personas contra los comportamientos suicidas.[126] Los programas de prevención del suicidio que se centran en las destrezas de la vida diaria y las destrezas sociales se derivan de las teorías cognitivas sociales,[130] que sostienen que el comportamiento suicida se atribuye, ya sea al aprendizaje directo y a modelos, o a características ambientales o individuales (por ejemplo, desesperanza). La incapacidad de emplear estrategias adecuadas para superar los factores estresantes inmediatos y para identificar y encontrar la solución a los problemas ha sido caracterizada entre las personas que intentan suicidarse.[131] Enseñarles y proporcionarles a los jóvenes las destrezas para afrontar los desafíos y factores estresantes de todos los días es, por lo tanto, un importante componente de la prevención del suicido.

Enfoques

Los programas de educación socio-emocional y de destrezas de crianza y relaciones familiares son dos enfoques para enseñar destrezas de superación y de resolución de problemas.

Programas de educación socio-emocional. Estos programas se centran en el desarrollo y el fortalecimiento de las destrezas de comunicación y resolución de problemas, la regulación emocional, la resolución de conflictos, la búsqueda de ayuda y las destrezas de superación. Abordan una variedad de factores de riesgo de suicidio y de protección contra el comportamiento suicida. Les proporcionan a los niños y a los jóvenes las destrezas para resolver problemas en las relaciones, la escuela y con otros niños o jóvenes, y ayudan a los jóvenes a manejar las otras influencias negativas asociadas al suicidio (como el consumo de sustancias).[126] Estos enfoques generalmente se imparten a todos los estudiantes de un grado o escuela en particular, aunque algunos programas se centran también en grupos de estudiantes considerados en alto riesgo de suicidio. Las oportunidades para practicar y reforzar las destrezas son una importante parte de los programas eficaces.[132]

Programas de destrezas de crianza y relaciones familiares. Estos programas les proporcionan apoyo a las personas que están a cargo de niños, y tienen el objetivo de reforzar las destrezas de crianza, mejorar las interacciones padre-hijo positivas y mejorar las destrezas y habilidades comportamentales y emocionales de los niños.[132] Este tipo de programa, por lo general, se diseña para los padres o personas a cargo de los niños de un rango de edad específico y puede ser autodirigido o impartido a familias de manera individual o en grupos de familias. Algunos de los programas tienen sesiones principalmente con los padres o personas a cargo de niños mientras que otros incluyen sesiones para los padres o personas a cargo de niños, los jóvenes y la familia. El contenido específico de los programas normalmente varía según la edad del niño, pero frecuentemente coincide en que incluye temas de desarrollo infantil, comunicación y relación padre-hijo, y de destrezas interpersonales y resolución de problemas del joven.

Resultados potenciales

- Reducción en la ideación suicida
- Reducción en los intentos de suicidio
- Reducción en los comportamientos de riesgo de suicidio (por ejemplo, depresión, ansiedad, problemas conductuales, abuso de sustancias)
- Mejoras en los comportamientos de búsqueda de ayuda
- Mejoras en la competencia social y las destrezas de regulación emocional
- Mejoras en las destrezas de resolución de problemas y manejo de conflictos

Evidencia

Hay varios programas de educación socio-emocional y de crianza y relaciones familiares que demostraron en las evaluaciones rigurosas mejorar la resiliencia y reducir los comportamientos problemáticos y los factores de riesgo de varios comportamientos, incluidos aquellos estrechamente relacionados con el suicidio, como la depresión, los comportamientos de internalización y el abuso de sustancias.[133]

Programas de educación socio-emocional. El *Programa de Jóvenes Conscientes de la Salud Mental (Youth Aware of Mental Health Program, YAM)* fue desarrollado para adolescentes de 14 a 16 años y usa el diálogo interactivo y representaciones de roles para enseñarles sobre los factores de riesgo y de protección asociados con el suicidio (incluidos el conocimiento acerca de la depresión y la ansiedad) y mejorar sus destrezas de resolución de problemas para afrontar los eventos adversos de la vida, el estrés, la escuela y otros problemas.[134] En un estudio controlado aleatorizado, por grupos, realizado en 10 países de la Unión Europea y 168 escuelas, los alumnos de las escuelas asignadas aleatoriamente al grupo del programa *YAM* tuvieron probabilidades significativamente menores de intentar suicidarse o de tener ideaciones suicidas graves en el seguimiento de los 12 meses en comparación con los de las escuelas de control que recibieron materiales educativos y la atención habitual. En términos generales, el riesgo relativo de intentos de suicidio juvenil entre los que estaban en el grupo de *YAM* se redujo en más del 50 % al indicar que de 1000 alumnos, cinco del grupo *YAM* intentaron suicidarse en comparación con 11 del grupo de control. Además, en cuanto a la ideación grave de suicidio, el riesgo relativo en el grupo *YAM* se redujo en 49.6 %.[134]

Otro ejemplo es el *Juego del Buen Comportamiento (Good Behavior Game, GBG)*, que es un programa para niños de 6 a 10 años que se imparte en la clase. El programa usa una estrategia de manejo del comportamiento en equipos, que promueve el buen comportamiento al establecer una expectativa clara de buen comportamiento y consecuencias para el comportamiento de inadaptación. El objetivo del programa *GBG* es crear un sistema social integrado en la clase que apoye la capacidad de aprender de todos los niños, con pocas manifestaciones de comportamiento agresivo o disruptivo.[135] En el programa participaron dos cohortes de niños durante los años escolares 1985-86 y 1986-87 cuando estos asistían a primer y segundo grado. Se analizaron un número de resultados proximales y distales entre las dos cohortes a lo largo del tiempo. Con respecto a los resultados distales relacionados con el suicidio, un análisis de los resultados del programa *GBG* indicó que las personas de la primera cohorte que fueron asignadas a participar en el programa *GBG* cuando estaban en primer grado, reportaron la mitad de las probabilidades ajustadas de ideación suicida y de intentos de suicidio al momento de la evaluación aproximadamente 15 años después (cuando tenían entre 19 y 21 años), en comparación con aquellas que habían estado en el entorno escolar estándar. El efecto beneficioso del programa se mantuvo en cuanto a la ideación suicida independientemente de que se hubieran incluido covariables de referencia.[135] El efecto del programa *GBG* en los intentos de suicidio fue menos robusto en algunos modelos ajustados, que incluyeron a cuidadores de salud mental. En la segunda cohorte de estudiantes que estaban en el programa *GBG*, ni sus resultados de ideación suicida ni sus intentos de suicidio fueron significativamente distintos a los del grupo de control.[135] Según los investigadores, esto pudo deberse a una posible falta de fidelidad en la implementación del programa, como menor mentoría y monitoreo a los maestros. También se halló que el programa *GBG* se asoció a un menor riesgo de abuso de sustancias posterior y de otros factores de riesgo en los estudiantes de la primera cohorte. Los resultados de la segunda cohorte fueron, en general, menores; pero apuntaban hacia la dirección deseada.[136]

Programas de destrezas de crianza y relaciones familiares. Los enfoques de capacitación en destrezas de crianza y familiares han demostrado tener un efecto prometedor en la prevención de factores de riesgo claves asociados al suicidio. Por ejemplo, el programa *Años Increíbles (Incredible Years, IY)* es un programa de capacitación integral en grupo para padres, maestros y niños que tiene el objetivo de reducir los problemas de conducta y de abuso de sustancias (dos importantes factores de riesgo de suicidio en los jóvenes) al mejorar los factores de protección como, por ejemplo, las interacciones y relaciones padre-maestro-niño positivas y receptivas, la autorregulación emocional y la competencia social (todos, factores de protección contra el suicidio).[132] El programa consta de entre 9 y 20 sesiones que se ofrecen en un entorno comunitario (por ejemplo, en centros religiosos, de recreación, de tratamiento de salud mental y hospitales). Varios estudios han demostrado el efecto del programa *IY* en la reducción de los síntomas de internalización, como la ansiedad y la depresión, y de los problemas de conducta en los niños.[137, 138] Este programa también se asoció a un mejoramiento en la capacidad de resolver problemas y de manejar conflictos; estas destrezas se mantuvieron en el seguimiento de 1 año.[139-141] El programa, además, demostró producir mayores beneficios con relación a los síntomas de internalización en los niños, según evaluaron las madres, en comparación con el grupo de control de aquellos en lista de espera, cuando se incluyeron los componentes de padre, niño y maestro.[132]

Asimismo, el programa *Fortalecimiento de las Familias, 10-14 (Strengthening Families 10–14)* implica sesiones para los padres, los jóvenes y las familias con la meta de mejorar las destrezas de los padres para disciplinar a sus hijos, manejar las emociones y los conflictos, y comunicarse con sus hijos; promover las destrezas interpersonales y de resolución de problemas de los jóvenes; y crear actividades familiares que forjen cohesión e interacciones positivas entre padres e hijos. La premisa del programa es que el desarrollo de estas destrezas, tanto en los padres como en los hijos, reducirá los comportamientos de internalización y el abuso de sustancias en la adolescencia, los cuales son dos importantes factores de riesgo de suicidio.[142] El programa *Fortalecimiento de las Familias* ha demostrado reducir significativamente los comportamientos de externalización, como la agresión o el consumo de alcohol y drogas entre los participantes jóvenes, y también la depresión y el consumo de alcohol y drogas entre las familias participantes.[142]





Identificación de las personas en riesgo y provisión de apoyo

Fundamento

Para poder reducir los suicidios, es necesario poner atención y brindar cuidados a las poblaciones vulnerables, ya que las tasas de comportamientos suicidas en estos grupos tienden a ser más altas que las tasas promedio. Estas poblaciones vulnerables incluyen, entre otras, a las personas con un nivel socioeconómico más bajo o afectadas por un problema de salud mental; las personas que hayan intentado suicidarse anteriormente; los veteranos y el personal militar en servicio activo; las personas que estén internadas en una institución, hayan sido víctimas de violencia o no tengan hogar; las personas que tengan un estatus de minoría sexual; y los miembros de ciertos grupos raciales o étnicos minoritarios.[8, 9, 12, 13, 143] El apoyo a las personas en riesgo requiere de la identificación proactiva de los casos y la respuesta eficaz, programas de intervención en crisis y tratamientos basados en la evidencia. Encontrar formas óptimas de identificar las personas en riesgo, adaptar los servicios para que sean más accesibles (por ejemplo, por Internet cuando sea lo apropiado) y motivar a las personas para que reciban atención médica basada en la evidencia (por ejemplo, por medios de tratamiento colaborativo) siguen siendo desafíos clave.[81, 144, 145] Si los servicios simplemente se mejoran o amplían, esto no garantiza que serán utilizados por las personas que más lo necesitan, ni que aumentará necesariamente la cantidad de personas que hagan seguimiento de las remisiones o tratamientos recomendados. Por ejemplo, algunas personas que viven en comunidades desfavorecidas podrían tener problemas sociales y económicos que pueden afectar adversamente su capacidad de acceder a los servicios de apoyo.[70]

Enfoques

Los siguientes enfoques se centran en la identificación y el apoyo a las personas que estén en mayor riesgo de suicidio.

Capacitación de personal de primera línea. Esta capacitación tiene el objetivo de instruir a maestros, entrenadores, clérigos, personal de respuesta a emergencias, proveedores de atención médica primaria y urgente, y a otras personas de la comunidad en identificar a las personas que podrían estar en riesgo de suicidio y a responder de manera eficaz, e incluso facilitarles servicios de búsqueda de tratamiento y de apoyo. Esta capacitación del personal de primera línea puede ser implementada en una variedad de entornos a fin de identificar y brindar apoyo a las personas en riesgo.[146]

Intervención en crisis. Estos enfoques brindan servicios de apoyo y remisión, que generalmente consisten en conectar a la persona que está en crisis (o a un amigo o familiar de la persona que está en riesgo) con un voluntario capacitado o personal profesional mediante una línea telefónica de ayuda, chat en línea, mensajes de texto o en persona. Los enfoques de las intervenciones en crisis tienen el objetivo de impactar los factores de riesgo de suicidio claves, que incluyen depresión, el sentimiento de desesperanza y la utilización subsiguiente de servicios de salud mental.[147] De manera similar a la reducción de los medios para el suicidio, las intervenciones en crisis pueden aumentar la distancia o el tiempo entre la persona que esté considerando suicidarse y el comportamiento dañino.

Tratamiento para las personas en riesgo de suicidio. Puede incluir varias formas de sicoterapia administrada por proveedores con licencia para ayudar a las personas con problemas de salud mental y otros factores de riesgo de suicidio, mediante la resolución de problemas y la regulación emocional. El tratamiento generalmente se hace en un formato individual o grupal entre pacientes y médicos, y puede ser de varias semanas de duración o continuo, según se necesite. Los tratamientos que emplean la terapia colaborativa (o sea, entre el paciente y el terapeuta o administrador de atención) o la terapia integrada (o sea, con vinculación entre la atención médica primaria y la de salud del comportamiento) pueden ayudar a animar a los pacientes y motivar su participación en la terapia y, por lo tanto, aumentar su retención y reducir su riesgo de suicidio.[148-150]



Tratamiento para prevenir los nuevos intentos. Estos enfoques generalmente incluyen hacer contacto de seguimiento y el uso de diversas modalidades (por ejemplo, con visitas domiciliarias, por correo, teléfono, correo electrónico) para motivar la participación de los sobrevivientes de un intento de suicidio reciente en un tratamiento continuo para prevenir los nuevos intentos de suicidio.[151] El tratamiento puede centrase en mejorar las destrezas de superación, la conciencia plena y otras destrezas de regulación emocional, y puede incluir tanto visitas domiciliarias de administración de casos para mejorar la adherencia al tratamiento y la continuidad de la atención médica, como terapia interpersonal individual o en grupo. Los enfoques que motivan la participación de las personas que han intentado suicidarse y las conectan con otras que lo han intentado y con proveedores son especialmente importantes porque muchas de ellas no se presentan a los servicios de atención médica posterior; entre el 12 y el 25 % volverán a intentarlo dentro del año, y entre el 3 y el 9 % de aquellas que sobreviven el intento mueren por suicidio entre 1 y 5 años después del intento inicial.[151]

Resultados potenciales

- Reducción en la ideación suicida
- Reducción en los intentos de suicidio
- Reducción en las tasas de suicidio
- Reducción en la depresión y los sentimientos de desesperanza
- Reducción en los nuevos intentos de suicidio
- Mejora en las destrezas de superación
- Aumento en la participación en el tratamiento y el cumplimiento con la toma de los medicamentos

Evidencia

La actual evidencia parece indicar que identificar a las personas que están en riesgo de suicidio y proporcionarles tratamiento y apoyo de manera continua puede impactar positivamente las tasas de suicidio y los factores de riesgo relacionados.

Capacitación del personal de primera línea. *Capacitación en Destrezas Aplicadas de Intervención contra el Suicidio (Applied Suicide Intervention Skills Training, ASIST)* es un programa de capacitación de amplia implementación que ayuda a los consejeros que atienden las líneas de ayuda, los trabajadores de emergencias y otro personal de primera línea (*gatekeeper*) a identificar a las personas suicidas y crear una conexión con ellas, comprender sus razones para vivir y morir, y ayudar a conectar a las que lo necesitan con los recursos disponibles, de manera segura. En un estudio en el que se usó un ensayo aleatorizado controlado, Gould, Cross, Pisani, Munfakh y Kleinman[152] evaluaron la capacitación en toda la red de líneas de ayuda de la *Red Nacional de Prevención del Suicidio* durante el período 2008-2009. Mediante el uso de los datos de 1410 personas suicidas que llamaron a 17 centros de esta red, los investigadores hallaron que las que habían hablado con consejeros que contaban con la capacitación del programa *ASIST* tenían probabilidades significativamente mayores de sentirse menos deprimidas, menos suicidas, menos abrumadas y más esperanzadas al final de la llamada que aquellas que habían hablado con consejeros que no contaban con esa capacitación. Los consejeros con la capacitación del programa *ASIST* fueron, además, más capaces de mantener a las personas en el teléfono por más tiempo y de establecer una conexión con ellas. Sin embargo, la capacitación en *ASIST* no produjo más evaluaciones de riesgo de suicidio integrales que la capacitación en cuidados habitual.[152]

La capacitación en la atención de primera línea también ha sido uno de los componentes principales del *Programa Garret Lee Smith para la Prevención del Suicidio, (Garret Lee Smith [GLS] Suicide Prevention Program),* que se ha implementado en 50 estados y en 50 tribus. En una evaluación de múltiples sitios se analizó el impacto que tuvo la capacitación del personal de primera línea en los intentos de suicidio y las muertes. Para ello se compararon los cambios en las tasas de suicidio y comportamientos suicidas no mortales entre personas jóvenes de 10 a 24 años en condados que implementaron la capacitación del programa *GLS* con la trayectoria observada en condados similares que no la implementaron. Los condados que implementaron esta capacitación tuvieron tasas de suicidio juvenil significativamente menores al año de su implementación.[153] Estos hallazgos representan una reducción de 1 muerte por suicidio por cada 100 000 jóvenes de 10 a 24 años, o la prevención de aproximadamente 237 muertes en ese grupo de edad, entre el 2007 y el 2010. Los condados que implementaron las actividades del programa *GLS* también tuvieron tasas de intentos de suicidio significativamente menores entre los jóvenes de 16 a 23 años al año siguiente de la implementación que otros condados similares que no implementaron estas actividades (4.9 menos intentos por cada 1000 jóvenes).[154] Más de 79 000 intentos de suicidio podrían haberse prevenido durante el periodo de análisis.

Intervención en crisis. Las líneas de ayuda para la prevención del suicidio son una forma de brindar intervenciones en crisis. En una evaluación sobre la eficacia de la *Red Nacional de Prevención del Suicidio* en prevenir suicidios, 1085 personas suicidas que llamaron a esta línea completaron una evaluación estándar de riesgo de suicidio y 380 de ellas completaron una evaluación de seguimiento entre 1 y 52 días después de la evaluación inicial (mediana = 13.5 días). Los investigadores hallaron que más de la mitad de las personas de la muestra inicial estaban seriamente considerando suicidarse cuando llamaron y que tenían un plan para llevarlo a cabo. Los investigadores también hallaron que entre los participantes del seguimiento, hubo una reducción significativa del dolor sicológico, la desesperanza y la intención de morir entre el inicio de la llamada (momento 1) y el seguimiento (momento 3).[155] Entre el momento 2 (el final de la llamada) y el momento 3, el efecto se sostuvo en cuanto al dolor sicológico y la desesperanza, pero no fue significativo en cuanto a la intención de morir, lo cual parece indicar que se necesita un mayor esfuerzo de acercamiento durante y después de la llamada en el caso de las personas con altos niveles de intento de suicidio.[155]

Tratamiento para las personas en riesgo de suicidio. El programa *Mejora del Estado de Ánimo y Promoción del Acceso al Tratamiento Colaborativo (Improving Mood—Promoting Access to Collaborative Treatment, IMPACT)* tiene el objetivo de prevenir el suicidio entre los pacientes mayores de atención médica primaria al reducir la ideación suicida y la depresión. El programa *IMPACT* facilita la formación de una alianza terapéutica, que es un plan personalizado de tratamiento que incluye las preferencias del paciente y un seguimiento proactivo (bisemanal durante la fase aguda y mensual durante la fase de continuación) por parte de un administrador de cuidados para la depresión.[156] El programa ha demostrado mejorar significativamente la calidad de vida y reducir la deficiencia funcional, la depresión y la ideación suicida de los pacientes durante los 24 meses de seguimiento[156,157] en comparación con los que recibieron los cuidados habituales.

El enfoque *Evaluación y Manejo Colaborativos del Riesgo de Suicidio (Collaborative Assessment and Management of Suicidality, CAMS)* es un enfoque terapéutico para la evaluación y el tratamiento específicos del suicidio. El enfoque flexible del programa se puede usar en todos los entornos de tratamiento independientemente de la orientación teórica del médico e implica que este y el paciente trabajan juntos en un proceso de evaluación interactivo a fin de crear un plan de tratamiento particular para paciente. Las sesiones son colaborativas e involucran una contribución constante por parte del paciente sobre lo que le está funcionando y lo que no, con el objetivo final de mejorar la alianza terapéutica y aumentar la motivación del paciente suicida para recibir tratamiento. El programa *CAMS* ha sido probado y respaldado en 6 estudios correlacionales,[144] en una variedad de entornos ambulatorios y de internación, y en un estudio aleatorizado controlado y otros adicionales que están en curso. Un estudio de viabilidad realizado con una muestra comunitaria de pacientes suicidas asignados aleatoriamente al programa *CAMS* o a un cuidado habitual mejorado (ingreso con un siquiatra o una enfermera especializada en siquiátrica seguido de 1-11 visitas con un administrador de casos y medicamentos, según sea necesario) se halló una mejor retención del tratamiento entre los del grupo *CAMS* y mejoras significativas en cuanto a la ideación suicida, los síntomas generales de sufrimiento emocional y el sentimiento de desesperanza en el seguimiento de los 12 meses.[158]

Otros ejemplos incluyen la *terapia dialéctica conductual (DBT, por sus siglas en inglés)* y la *terapia familiar basada en el apego (ABFT, por sus siglas en inglés)*. La terapia dialéctica conductual es una terapia multicomponente para personas que están en alto riesgo de suicidio y que podrían tener dificultades con la impulsividad y con la regulación emocional. Los componentes de esta terapia incluyen terapia individual, capacitación en destrezas grupal, instrucción telefónica entre sesiones y un equipo de terapeutas para la consulta. En un estudio controlado aleatorizado de mujeres que habían tenido recientemente un comportamiento suicida o de autodaño, aquellas que recibieron *terapia dialéctica conductual* tuvieron la mitad de las probabilidades de tener un intento de suicidio en el seguimiento de los dos años que aquellas que recibieron el tratamiento comunitario (23 % comparado con 46 %), requirieron menos hospitalización por ideación suicida y tuvieron menor riesgo médico respecto de todos los intentos de suicidio y actos de autodaño combinados.[159]

La *terapia familiar basada en el apego* es un programa para adolescentes de 12 a 18 años que tiene el objetivo de tratar el trastorno depresivo mayor clínicamente diagnosticado, eliminar la ideación suicida y reducir la ansiedad disposicional.[160] En un estudio controlado aleatorizado sobre la terapia familiar basada en el apego se halló que los adolescentes suicidas asignados a esta terapia tuvieron una mejora significativamente más alta en cuanto a la ideación suicida en las 24 semanas de seguimiento que aquellos asignados a una terapia habitual mejorada. Asimismo, un porcentaje significativamente más alto de participantes que recibía la *terapia familiar basada en el apego* reportó no haber tenido ideación suicida la semana anterior a la evaluación de las 12 semanas en comparación con los adolescentes que recibieron un cuidado habitual mejorado (69.2 % comparado con 34.6 %), y a las 24 semanas (82.1 % comparado con 46.2 %).[160]

El proyecto *Traducción de Iniciativas para la Depresión en Soluciones Eficaces (Translating Initiatives for Depression into Effective Solutions, TIDES)* usa un enlace de cuidados para la depresión para vincular la atención médica primaria con los servicios de salud mental. Este enlace de cuidados para la depresión evalúa y educa a los pacientes, y hace seguimiento tanto con los pacientes como con los proveedores entre las visitas de atención médica primaria a fin de optimizar el tratamiento. Estos cuidados colaborativos aumentan la eficacia de la forma de proporcionar los servicios de salud mental al insertarlos en el entorno de atención médica primaria, donde se detectan originalmente muchas afecciones mentales y luego se tratan, en el caso de la mayoría de los pacientes. En una evaluación del proyecto *TIDES* se halló una reducción significativa en los puntajes de gravedad de la depresión en el 70 % de los pacientes de atención médica primaria.[161] Los pacientes tratados con el enfoque *TIDES* también demostraron cumplimiento con la toma de los medicamentos y las visitas de seguimiento en un 85 y 95 %, respectivamente.[161]

Tratamiento para prevenir los nuevos intentos. Hay varias estrategias que apuntan a prevenir los nuevos intentos, que han demostrado tener un impacto en la reducción de las muertes por suicidio. Por ejemplo, el programa *Intervención Breve en Sala de Emergencia con Visitas de Seguimiento (Emergency Department Brief Intervention with Follow-up Visits)* implica una sesión informativa de una hora al momento del alta hospitalaria, que aborda la ideación suicida e intentos de suicidio, el sufrimiento emocional, los factores de riesgo de suicidio y de protección contra el suicidio, alternativas al autodaño y opciones de remisiones combinada con contactos de seguimiento a lo largo de 18 meses (en las semanas 1, 2, 4, 7 y 11, y los meses 4, 6, 12 y 18). Los contactos de seguimiento se hacen por teléfono o mediante visitas domiciliarias, según el esquema específico, por hasta 18 meses. En un estudio controlado aleatorizado que inscribió a personas que habían intentado suicidarse, en ocho salas de emergencia hospitalarias, en cinco países (Brasil, India, Sri Lanka, Irán y China) se halló que proporcionar una breve intervención, seguida de nueve visitas de seguimiento a lo largo de 18 meses, se asoció a una cantidad significativamente menor de muertes por suicidio en comparación con el grupo del tratamiento habitual (0.2 % comparado con 2.2 %, respectivamente).[162]

Otro ejemplo de tratamiento para la prevención de nuevos intentos implica *enfoques de contactos de seguimiento activos* como enviar tarjetas postales o cartas y hacer llamadas telefónicas a fin de incrementar la sensación de conexión del paciente con los proveedores de atención médica y reducir su aislamiento.[151] Estos enfoques incluyen la expresión de apoyo e interés por el bienestar de la persona y generalmente invitan a los pacientes a reconectarse con su proveedor. Los contactos se hacen de manera periódica (por ejemplo, mensualmente o cada tantos meses en los primeros 12 meses posteriores al alta; algunos de los programas continúan los contactos durante dos años o más). En los metanálisis realizados por Inagaki et al[151] se halló que las intervenciones para la prevención de los nuevos intentos de suicidio en los pacientes admitidos a una sala de emergencias por intento de suicidio redujeron los nuevos intentos en aproximadamente el 17 % durante hasta los 12 meses posteriores al alta; sin embargo, los efectos de estos enfoques en

los nuevos intentos más allá de los 12 meses no han sido evaluados todavía.[151] Además, debido a que tanto la cantidad de ensayos incluidos en este metanálisis como el tamaño de las muestras relacionadas fueron reducidos, no fue posible determinar el efecto que tuvieron sobre el suicidio los enfoques de contacto y seguimiento activos.

En un estudio controlado aleatorizado sobre el enfoque de contactos y seguimiento a largo plazo para la prevención poscrisis del suicidio, Motto and Bostrom[163] hallaron que los pacientes que no aceptaron cuidados continuos, pero que fueron aleatorizados para ser contactados por carta cuatro veces al año mostraron tasas de suicidio menores durante los dos años de seguimiento que aquellos del grupo de control que no recibieron estos contactos adicionales. Otros estudios también han mostrado que las cartas poscrisis y las tarjetas de superación tienen un efecto de protección contra la ideación suicida y los intentos de suicidio.[164, 165]

Por último, el enfoque de *terapia cognitiva conductual para la prevención del suicidio (CBT-SP, por sus siglas en inglés)* es un ejemplo de enfoque terapéutico para la prevención de nuevos intentos. Usa un enfoque de reducción del riesgo y de prevención de recaídas que incluye el análisis de los factores de riesgo proximales y los factores estresantes (por ejemplo, los problemas en las relaciones, las dificultades relacionadas con la escuela o el trabajo) anteriores y posteriores al intento de suicidio; la creación de un plan de seguridad; desarrollo de destrezas y educación sicológica. La terapia *CBT-SP* asimismo contiene módulos de destrezas familiares que se centran en el apoyo y los patrones de comunicación familiar, y en mejorar las destrezas de resolución de problemas de la familia. En un estudio controlado aleatorizado sobre este enfoque se halló que, en comparación con el tratamiento habitual, la terapia cognitiva de 10 sesiones ambulatorias diseñada para prevenir la repetición de los intentos de suicidio mostró una reducción del 50 % en la probabilidad de nuevos intentos de suicidio entre los adultos que habían sido admitidos a una sala de emergencias por un intento de suicidio.[166]




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Reducir los daños y prevenir el riesgo futuro

Fundamento

En los Estados Unidos y en el resto del mundo, cada año millones de personas sufren el duelo causado por un suicidio.[5] Se ha mostrado que el riesgo y los factores de riesgo de suicidio aumentan entre las personas que han sufrido la pérdida de un amigo o persona de su grupo, familiar, compañero de trabajo u otro contacto cercano a causa del suicidio.[167] Por lo tanto, es muy importante brindarles cuidado y atención a estas personas que están en duelo. A pesar de las buenas intenciones, frecuentemente la respuesta de los medios y de otros puede aumentar este riesgo. Por ejemplo, las investigaciones muestran que la exposición al informe sensacionalizado o desinformado de un suicidio puede aumentar el riesgo de suicidio entre las personas vulnerables y puede contribuir involuntariamente a lo que se denomina suicidio por imitación o contagio.[168, 169]

Enfoques

Algunos de los enfoques que se pueden usar para reducir el daño y el futuro riesgo de suicidio incluyen la intervención posterior y el informe y difusión de mensajes seguros tras el suicidio.

Intervenciones posteriores. Son enfoques que se implementan *después* de que haya ocurrido un suicidio y pueden incluir sesiones de comentario, consejería o un grupo de apoyo para el duelo, para los amigos, familiares y otros contactos cercanos sobrevivientes. Por lo general, no se ha evaluado el impacto de estos programas sobre el suicidio, los intentos de suicidio ni la ideación suicida, pero pueden reducir la culpa del sobreviviente, los sentimientos de depresión y el duelo complicado.[170]

Informe y mensajes seguros en relación con el suicidio. La forma en que se comunica información sobre un suicidio reciente al público (por ejemplo, en una asamblea escolar, los medios de comunicación en masa, los medios sociales) puede incrementar el riesgo de suicidio entre las personas vulnerables y contribuir involuntariamente al suicidio por imitación. Los informes que incluyen mensajes de prevención del suicidio, historias de esperanza y resiliencia, factores de riesgo y protección, y enlaces a recursos de ayuda (por ejemplo, líneas de ayuda), y que evitan sensacionalizar el evento y reducir su causa a un solo factor, pueden ayudar a reducir la probabilidad de suicidio por imitación.[171]

Resultados potenciales

- Reducción en la ideación suicida
- Reducción en los intentos de suicidio
- Reducción en las tasas de suicidio
- Reducción en el sufrimiento sicológico
- Mejoras en el informe tras el suicidio
- Reducción en el efecto de imitación relacionado con el suicidio



Evidencia

La evidencia actual sugiere que las intervenciones posteriores y el informe y mensajes seguros pueden afectar los factores de riesgo de suicidio y de protección contra el suicidio.

Intervención posterior. Un ejemplo de programa de intervención posterior con evidencia de efecto sobre los factores de riesgo de suicidio y de protección contra el suicidio es el *Servicio de Respuesta StandBy (o solo StandBy, según su abreviación). StandBy* brinda apoyo de acercamiento telefónico y presencial a los clientes mediante un equipo profesional de respuesta a crisis. Los coordinadores del sitio crean planes personalizados de administración de casos, en los que se remite a los clientes a otros servicios existentes de la comunidad según sus necesidades.[172] En un estudio realizado por Visser, Comans y Scuffham,[172] los clientes que estaban en el grupo de *StandBy* tuvieron probabilidades significativamente menores de estar en alto riesgo de suicidio (ideación suicida e intentos de suicidio) y tuvieron menos sufrimiento sicológico que los que estaban en el grupo de duelo de control, que no habían tenido contacto con el programa *StandBy* (48 y 64 %, respectivamente). Asimismo, las investigaciones parecen indicar que los enfoques de intervención posterior activa, en los que el acercamiento a los sobrevivientes del suicidio ocurre en el lugar del suceso, se asocian al inicio más pronto del tratamiento, mayor asistencia a reuniones de grupos de apoyo y asistencia a más reuniones, en comparación con la intervención posterior pasiva (o sea, los enfoques en los que los sobrevivientes se autorremiten para recibir servicios).[173]

Informe y mensajes seguros en relación con el suicidio. Una forma de asegurar que se informe de manera segura y se difundan mensajes seguros sobre el suicidio es animar a los medios noticiosos a adherirse a las *Recomendaciones para reportar el suicidio*(http://www.reportingonsuicide.org). La evidencia más persuasiva que respalda estas recomendaciones para el informe de suicidios proviene de Austria. Tras un marcado aumento en la cantidad de suicidios en el tren subterráneo de Viena, se incorporaron pautas para los medios y se usó un diseño de series temporales interrumpidas para evaluar el efecto de las pautas a nivel nacional en los suicidios subsiguientes. Debido a los cambios en la calidad y la cantidad de los informes noticiosos hubo una reducción significativa de 81 suicidios al año a nivel nacional.[169] Por último, las investigaciones parecen indicar no solo que informar sobre los suicidios de una manera negativa (por ejemplo, informar sobre los mitos relativos al suicidio y la repetición) tiene efectos negativos respecto al suicidio, sino también que informar sobre las destrezas de superación ante la adversidad puede mostrar efectos protectores contra el suicidio.[174] Informar sobre la ideación suicida sola (sin informar sobre un suicidio o intento de suicidio) conjuntamente con la descripción del "dominio" que se tuvo sobre una situación de crisis en la que se superaron las adversidades se asoció a una reducción significativa en las tasas de suicidio durante el periodo inmediatamente posterior a tal informe.[174]



Participación de los sectores

El sector de salud pública puede cumplir una función importante y única para abordar el suicidio. Las agencias de salud pública, que generalmente colocan la prevención al frente de sus esfuerzos y trabajan para lograr un amplio efecto a nivel poblacional, pueden aportar liderazgo y recursos críticos para abordar este problema. Estas agencias pueden, por ejemplo, actuar como medios para la convocación y reunión de las organizaciones socias y las partes interesadas a fin de planificar, priorizar y coordinar los esfuerzos de prevención del suicidio. Asimismo, las agencias de salud pública se encuentran bien posicionadas para recoger y difundir datos, implementar medidas preventivas, evaluar programas y hacer seguimiento del progreso. Si bien el sector de salud pública puede cumplir una función de liderazgo en la prevención del suicidio, las estrategias y enfoques descritos en este paquete técnico no se pueden lograr a través de este sector solo. Según se menciona en la *Estrategia Nacional para la Prevención del Suicidio,*[1] la integración y coordinación de las actividades de prevención en todos los sectores y entornos son esenciales para ampliar el alcance y el efecto de los esfuerzos de prevención del suicidio.

Otros sectores que son vitales para la implementación de este paquete incluyen, entre otros, a los sectores de educación, gobierno (local, estatal y federal), servicios sociales, servicios de salud, comercio, trabajo, justicia, vivienda, medios de comunicación y a las organizaciones que conforman al sector de la sociedad civil, como las organizaciones religiosas, las organizaciones juveniles, las fundaciones y otras organizaciones no gubernamentales. De forma colectiva, estas organizaciones pueden lograr una diferencia en la prevención del suicidio al afectar los diversos contextos y riesgos subyacentes que contribuyen al suicidio.

Las estrategias y enfoques descritos en este paquete técnico se resumen en el Apéndice junto con los sectores relevantes que se encuentran bien posicionados para liderar los esfuerzos de implementación. Por ejemplo, el sector comercio y trabajo, y el de salud (incluidas las compañías aseguradoras, los proveedores y los sistemas de salud), así como las entidades gubernamentales están en la mejor posición para implementar los programas y las políticas que sirven para el *Fortalecimiento de los apoyos económicos* y el *Fortalecimiento del acceso a los cuidados relacionados con el suicidio y de su prestación*. Estos tipos de apoyos van más allá del cambio de comportamiento individual y requieren del compromiso y apoyo de aquellos sectores que pueden abordar directamente algunos de los riesgos subyacentes y contextos ambientales que aumentan el riesgo de suicidio. Las entidades de salud pública pueden cumplir un papel importante al reunir y sintetizar información que sirve para conformar políticas, crear conciencia y evaluar la eficacia de diversas políticas. Más aún, la alianza con organizaciones no gubernamentales y comunitarias puede ser instrumental para conseguir respaldo para las políticas que afectan a las personas y las familias y crear conciencia sobre estas políticas.

El sector de salud pública ha estado a la vanguardia de muchos esfuerzos de prevención basados en la comunidad y ha estado trabajando colaborativamente con organizaciones escolares y comunitarias para cambiar las normas sociales e influir en el comportamiento relacionado con la salud de manera positiva. El sector de salud pública es muy adecuado para tomar un rol de liderazgo similar para *Promover la conexión* a través de actividades que favorecen el cambio en las normas de los semejantes y motivan la participación en la comunidad, y para apoyar el desarrollo, la evaluación y la adopción de programas eficaces para la *Enseñanza de destrezas de superación y resolución de problemas* a fin de prevenir el riesgo de suicidio en primer lugar. Estos programas generalmente se imparten en entornos escolares y comunitarios, lo cual hace que las organizaciones educativas y no gubernamentales sean socios vitales para la prevención.

Por otro lado, las empresas, los lugares de trabajo y las entidades locales y estatales son quienes están en mejor posición para establecer políticas y respaldar las prácticas que sirven para *Crear ambientes protectores* en los lugares donde las personas viven, trabajan y se entretienen. Las entidades de salud pública pueden cumplir una función importante al reunir y sintetizar información, trabajar con otras agencias gubernamentales (por ejemplo, justicia penal, defensa) y agencias dentro del poder ejecutivo de su gobierno estatal o local para apoyar políticas y otros enfoques, y evaluar la eficacia de las medidas tomadas. De manera similar, las entidades de salud pública pueden aliarse con escuelas, lugares de trabajo y organizaciones comunitarias para implementar y evaluar los programas, prácticas y políticas de prevención que apuntan a crear ambientes de apoyo seguros y saludables.

Por último, en este paquete se incluye un número de intervenciones que se pueden impartir en entornos hospitalarios, de atención médica primaria, de cuidado de la salud mental y comunitarios para la *Identificación de las personas en riesgo y provisión de apoyo*. Las actividades e intensidad de muchas de estas intervenciones requieren la experiencia de profesionales que cuenten con licencia y estén capacitados para administrar apoyo crítico de intervención. Los sectores de salud, servicios sociales y justicia pueden trabajar colaborativamente para apoyar a las personas que estén en alto riesgo de suicidio y a sus familias. Estas actividades requieren, asimismo, que se coordinen los apoyos entre varios proveedores de servicios y organizaciones comunitarias.

Independientemente de la estrategia que se use, se necesitará la acción de muchos sectores para que se logre la implementación exitosa de este paquete técnico. En este sentido, todos los sectores pueden cumplir un papel importante e influyente para prevenir el suicidio en primer lugar y reducir el daño inmediato y a largo plazo de los comportamientos suicidas al ayudar a aquellos que estén pasando por un momento de crisis a recibir los servicios y el apoyo que necesitan.



Monitoreo y evaluación

El monitoreo y la evaluación son componentes necesarios del enfoque de salud pública para la prevención. Es importante tener datos oportunos y confiables para monitorear el alcance del problema y evaluar el efecto de los esfuerzos de prevención. Estos datos también son necesarios para la planificación e implementación de los esfuerzos de prevención, y es importante que se reúnan de manera continua y sistemática.



Sin embargo, también es importante que se reúnan datos que sean uniformes y coherentes entre todos los sistemas. Tener datos coherentes les permite a la salud pública y a otras entidades poder medir mejor el alcance del problema, identificar a los grupos en alto riesgo y monitorear los efectos de los programas y las políticas de prevención. En este momento es común que los distintos sectores, agencias y organizaciones empleen diferentes definiciones de ideación suicida, comportamiento suicida y muerte por suicidio, lo cual puede hacer que sea difícil monitorear uniformemente determinados criterios de valoración a lo largo del tiempo y en los distintos sectores. Por ejemplo, la forma en que se clasifican las muertes puede cambiar de una jurisdicción a la otra, y puede cambiar según estándares médicos o médico-legales locales.[4] Al ofrecer definiciones uniformes y recomendaciones en cuanto a los datos sobre la violencia autoinfligida que se deben recoger, los CDC proporcionan un marco que ayuda a garantizar que los datos se recojan de manera uniforme en todos los sistemas de vigilancia.[4]

Existen sistemas de vigilancia a nivel federal, estatal y local. Es importante evaluar la disponibilidad de datos de vigilancia y de sistemas de datos en todos estos niveles para identificar y abordar las brechas que haya en estos sistemas. El *Sistema Nacional de Estadísticas Vitales (NVSS, por sus siglas en inglés)*[7] de los CDC y el *Sistema Nacional de Notificación de Muertes Violentas (NVDRS)*[175] son ejemplos de sistemas de vigilancia que proporcionan datos sobre las muertes por suicidio. *NVSS* es un sistema de vigilancia en todo el país que recoge datos demográficos, geográficos y sobre las causas de muerte que aparecen en los certificados de defunción.[7] *NVDRS* es un sistema de vigilancia a nivel estatal (actualmente en 40 estados, el Distrito de Columbia y Puerto Rico) que combina los datos de los certificados de defunción, informes policiales e informes de funcionarios o médicos forenses a fin de proveer información detallada sobre las circunstancias de las muertes violentas, incluido el suicidio, que pueden ayudar a las comunidades a guiar los enfoques para la prevención.[175] Los datos del Equipo de Revisión de Muertes Infantiles[176] y del Equipo de Revisión de Muertes por Suicidio (que hay en varios estados) ofrecen otro recurso para identificar las muertes y obtener conocimientos acerca de los vacíos en los servicios, los sistemas y los factores de riesgo de suicidio modificables.

El *Programa de Seguimiento de Todas las Lesiones del Sistema Electrónico Nacional de Vigilancia de Lesiones (NEISS-AIP, por sus siglas en inglés)* proporciona datos representativos a nivel nacional sobre todos los tipos y causas de lesiones no mortales tratadas en salas de emergencia en hospitales estadounidenses, y puede usarse para evaluar las tasas y tendencias a nivel nacional de lesiones autoinflingidas, por causa (por ejemplo, caídas, envenenamiento, etc.), edad, raza u origen étnico, sexo, disposición (dónde va la persona lesionada cuando se le da el alta de la sala de emergencias).[6]

Además de información sobre las muertes y las lesiones no mortales, algunos sistemas de vigilancia también proporcionan estimados nacionales, estatales y algunos locales sobre el comportamiento suicida. El *Sistema de Vigilancia de los Comportamientos de Riesgo en los Jóvenes (YRBSS)* recoge información sobre una muestra representativa a nivel nacional de estudiantes de 9.º a 12.º grado y es un recurso clave para el monitoreo de comportamientos de riesgo para la salud entre los jóvenes, incluso de si han considerado seriamente suicidarse, si han intentado suicidarse, hecho planes para suicidarse o necesitado el tratamiento de un médico o enfermera por un intento de suicidio cuyo resultado haya sido una lesión, envenenamiento o sobredosis.[177] Los datos del *YRBSS* se obtienen a partir de una encuesta nacional escolar realizada por los CDC y de encuestas realizadas por agencias de salud y educacionales a nivel estatal, territorial y tribal, y en distritos escolares urbanos grandes.[177] La*Encuesta Nacional sobre el Consumo de Drogas y la Salud (NSDUH)*[50] es una encuesta anual de la población civil no internada en una institución, de 12 años y mayor. La *NSDUH* proporciona estimaciones tanto a nivel nacional como estatal sobre el consumo de sustancias (alcohol, tabaco, drogas ilegales y uso no médico de medicamentos recetados); la salud mental (enfermedad mental en el año anterior, enfermedades concomitantes); y la utilización de servicios, junto con ideación suicida, planes de suicidarse e intentos de suicidio. Esta encuesta es un recurso clave para hacer seguimiento de las tendencias de los factores de riesgo relacionados con el suicidio en la población y ayudar a identificar los grupos que están en mayor riesgo.[50]

También es importante a todos los niveles (local, estatal y federal) para abordar las brechas en la respuesta, hacer seguimiento del progreso de los esfuerzos de prevención y evaluar el efecto de estos esfuerzos, e incluso de este paquete técnico. Los datos de las evaluaciones, que resultan de la implementación y el monitoreo de los programas, son esenciales para informar sobre lo que funciona y lo que no funciona para la reducción de las tasas de suicidio y respecto de los factores de riesgo y de protección relacionados. Las teorías del cambio y los modelos lógicos que identifican resultados a corto, mediano y largo plazo son una parte importante de la evaluación de los programas.

La base de evidencia para la prevención del suicidio ha avanzado sustancialmente en las últimas décadas. Sin embargo, se necesita hacer investigación adicional para entender el efecto que tienen los programas, prácticas y políticas sobre el suicidio (y los intentos de suicidio, como mínimo) en contraposición con meramente examinar la eficacia que tienen respecto de los factores de riesgo. También se necesitan más investigaciones para examinar la eficacia de las estrategias de prevención primaria (antes de que ocurra el riesgo) y de las estrategias a nivel comunitario para la prevención del suicidio a nivel poblacional. Será importante que los investigadores estudien la eficacia de distintas combinaciones de las estrategias y enfoques incluidos en este paquete. La mayoría de las evaluaciones existentes se centran en enfoques que han sido implementados de manera aislada, pero existe el potencial de entender los efectos sinérgicos que tienen dentro de un enfoque de prevención integral. Por último, también hay muchas oportunidades potenciales para construir y fortalecer la colaboración entre las distintas áreas programáticas (por ejemplo, prevención de la violencia, prevención del abuso de sustancias) a fin de evaluar el efecto que tienen los distintos enfoques sobre diversos criterios de valoración.

Conclusión

El suicidio es un problema de salud pública grave. Las tasas de suicido han estado aumentando por más de una década y los costos alcanzan fácilmente los miles de millones de dólares cada año. Si bien el suicidio es un resultado estadísticamente raro, tiene un impacto humano con un efecto dominó de profundo alcance. Es probable que cada uno de nosotros interactúe con sobrevivientes de suicidio —personas que han pasado por la experiencia y personas que piensan a diario en el suicidio—, ya sea en nuestro hogar, lugar de trabajo o comunidad. El suicidio y los intentos de suicidio son problemas de salud pública que preocupan a la sociedad. Hay un número de barreras que han impedido el progreso. Estas incluyen, por ejemplo, el estigma relacionado con la búsqueda de ayuda, la enfermedad mental y el hecho de ser sobreviviente; también incluyen el temor relacionado con preguntarle a alguien sobre los pensamientos suicidas. Afortunadamente, al igual que muchos problemas de salud pública, el suicidio es prevenible,[1,5] y se está haciendo más al respecto ahora que nunca, según queda evidenciado por el trabajo de la Alianza Nacional de Acción para la Prevención del Suicidio,[39,40,75,88] la publicación del primer informe mundial sobre el suicidio[5] y la obtención de datos de vigilancia más oportunos, entre otros.

En un esfuerzo por seguir impulsando el campo de trabajo y la sociedad más hacia la prevención, este paquete técnico incluye estrategias y enfoques que se usarían idealmente de manera integral, multisectorial y en niveles múltiples. Incluye estrategias y enfoques que previenen el riesgo de suicidio en primer lugar, así como estrategias centradas en reducir los daños inmediatos y a largo plazo del comportamiento suicida. También incluye estrategias que varían, desde enfoques que abarcan a la población entera independientemente de su nivel de riesgo, a estrategias cuyo objetivo es apoyar a las personas que tienen el mayor riesgo. Este paquete técnico fundamentalmente extiende los límites de las estrategias típicas de prevención y tiene en cuenta los enfoques que van más allá del cambio del comportamiento individual, a fin de abordar mejor los factores de riesgo que afectan a las comunidades y poblaciones de manera más generalizada (por ejemplo, políticas económicas para fortalecer la seguridad de vivienda y financiera).

Mientras la base de evidencias sigue aflorando, la colección de programas, políticas y prácticas que se delinean aquí están disponibles en este momento para ser implementadas. Conforme con la buena práctica de salud pública, el objetivo es que el monitoreo y la evaluación cumplan un papel importante en esa implementación. Asimismo, a medida que haya más evidencia disponible, este paquete técnico podrá refinarse para que refleje el estado corriente de la ciencia.

Para terminar, y de acuerdo con el mensaje de resiliencia expresado por aquellos que han vivido esta experiencia, "la esperanza, la ayuda y la sanación son posibles".



"La esperanza, la ayuda y la sanación son posibles".



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Apéndice: Resumen de estrategias y enfoques para la prevención del suicidio

Estrategia	Enfoque o programa, Práctica o política	Mejor evidencia disponible			Sectores principales[1]
		Suicidio	Intentos de suicidio o ideación sobre el suicidio	Otros factores de riesgo de suicidio o de protección contra el suicidio	
Fortalecimiento de los apoyos económicos	**Fortalecimiento de la seguridad financiera del hogar**				Gobierno (local, estatal, federal) Comercio/trabajo
	Programas de beneficios por desempleo	✓		✓	
	Otros apoyos (ingresos)	✓			
	Políticas para la estabilidad de vivienda				Gobierno (local, estatal, federal)
	Programa de Estabilización Vecinal			✓	
Fortalecimiento del acceso a los cuidados relacionados con el suicidio y de su prestación	**Cobertura de afecciones mentales en las pólizas de seguro médico**				Gobierno (local, estatal, federal) Atención médica Servicios sociales
	Leyes de paridad de la salud mental	✓		✓	
	Reducir la falta de proveedores en las áreas subatendidas				
	Cuerpo Nacional de Salud (NHSC)			✓	
	Telesalud mental (TMH)			✓	
	Cuidados más seguros con relación al suicidio mediante cambios a nivel de sistema				
	Atención Perfecta de la Depresión Henry Ford (precursora de Cero Suicidios)	✓		✓	
Creación de ambientes protectores	**Reducción del acceso a medios letales entre las personas en riesgo de suicidio**				Gobierno (local, estatal, federal) Salud pública Atención médica
	Intervenciones en los lugares propicios para el suicidio	✓			
	Prácticas de almacenamiento seguro		✓	✓	
	Consejería en Sala de Emergencias sobre el Acceso a Medios Letales (ED CALM)			✓	
	Políticas y cultura a nivel de organización				Comercio/trabajo Justicia Gobierno (local, estatal, federal)
	Juntos por la Vida	✓			
	Programa de Prevención del Suicidio de la Fuerza Aérea de los EE. UU.	✓		✓	
	Prevención del suicidio en centros correccionales	✓			
	Políticas basadas en la comunidad para reducir el consumo excesivo de alcohol				Gobierno (local, estatal) Comercio/trabajo
	Regulación de la densidad de los lugares de venta de alcohol	✓		✓	
Fomento de la conexión	**Programas de normas de semejantes**				Salud pública Educación
	Fuentes de Fortaleza			✓	
	Actividades de participación en la comunidad				Salud pública Gobierno (local)
	Enverdecimiento de áreas urbanas vacantes			✓	

*Esta columna hace referencia a los sectores principales que se encuentran bien posicionados para traer liderazgo y recursos a los esfuerzos de implementación. Para cada estrategia, hay muchos otros sectores, como el de organizaciones no gubernamentales, que son esenciales para la planificación de la prevención y la implementación de actividades programáticas específicas.

Estrategia	Enfoque o programa, Práctica o política	Mejor evidencia disponible			Sectores principales[1]
		Suicidio	Intentos de suicidio o ideación sobre el suicidio	Otros factores de riesgo de suicidio o de protección contra el suicidio	
Enseñanza de destrezas de superación y resolución de problemas	**Programas de educación socio-emocional**				Salud pública Educación
	Jóvenes Conscientes de la Salud Mental		✓	✓	
	Juego del Buen Comportamiento		✓	✓	
	Enfoques de destrezas de crianza y relaciones familiares				Salud pública Educación
	Años Increíbles			✓	
	Fortalecimiento de las Familias, 10-14			✓	
Identificación de las personas en riesgo y provisión de apoyo	**Capacitación del personal de primera línea**				Salud pública Atención médica
	Capacitación en Destrezas Aplicadas de Intervención contra el Suicidio			✓	
	Programa Garret Lee Smith para la Prevención del Suicidio	✓	✓		
	Intervención en crisis				Salud pública Servicios sociales
	Red Nacional de Prevención del Suicidio		✓	✓	
	Tratamiento para las personas en riesgo de suicidio				Atención médica Servicios sociales Justicia
	Mejora del Estado de Ánimo y Promoción del Acceso al Tratamiento Colaborativo (IMPACT)		✓	✓	
	Evaluación y Manejo Colaborativos del Riesgo de Suicidio (CAMS)		✓	✓	
	Terapia dialéctica conductual (DBT)		✓	✓	
	Terapia familiar basada en el apego (ABFT)		✓		
	Traducción de Iniciativas para la Depresión en Soluciones Eficaces (TIDES)			✓	
	Tratamiento para prevenir los nuevos intentos				Atención médica Servicios sociales
	Intervención Breve en Sala de Emergencia con Visitas de Seguimiento	✓			
	Enfoques de contactos de seguimiento activos	✓	✓		
	Terapia cognitiva conductual para la prevención del suicidio		✓		
Reducir los daños y prevenir el riesgo futuro	**Intervención posterior**				Atención médica
	Servicio de Respuesta StandBy		✓	✓	
	Informe y mensajes seguros en relación con el suicidio				Salud pública Medios de comunicación
	Directrices para los medios	✓			

*Esta columna hace referencia a los sectores principales que se encuentran bien posicionados para traer liderazgo y recursos a los esfuerzos de implementación. Para cada estrategia, hay muchos otros sectores, como el de organizaciones no gubernamentales, que son esenciales para la planificación de la prevención y la implementación de actividades programáticas específicas.

Para obtener más información

Para informarse más sobre la prevención del suicidio, llame al 1-800-CDC-INFO o visite las páginas web de los CDC sobre la prevención de violencia en www.cdc.gov/violenceprevention.

National Center for Injury Prevention and Control
Division of Violence Prevention

AK2017
MLS–290988

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 14 May 2018 02:47:29 +0000
To: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Subject: FW: CDC Commentary for a June Vital Signs on Suicide

Hi Brandy,
I wanted to share this email chain with you in case the VS office wants to work with AJPH in the future. Dr. Morabia was very receptive to a commentary to the VS even though ours didn't get accepted.
Thanks,
Deb

From: American Journal of Public Health Editor
Sent: Wednesday, April 25, 2018 6:57 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Re: CDC Commentary for a June Vital Signs on Suicide

Dear Deb Stone,
I am just as disappointed as you are that this did not work out. I will consider other pieces in the future. We may want to prepare them in advance in such a way that they do not fail.
Sincerely,
Alfredo Morabia, MD, PhD
Editor-in-Chief, AJPH
Twitter | AJPH | Podcast

From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Sent: Monday, April 23, 2018 11:43 AM
To: American Journal of Public Health Editor
Subject: RE: CDC Commentary for a June Vital Signs on Suicide

Dear Dr. Morabia,
I thank you for your time and consideration. My regrets that the piece was not up to AJPH's standards.
I plan to work with the authors to consider next steps for highlighting the Vital Signs more effectively.
Again, I appreciate your consideration and support of the intended outcome.
I hope you may consider another commentary linked to a Vital Signs in the future.
Sincerely,
Deb Stone

From: American Journal of Public Health Editor <editorajph@qc.cuny.edu>
Sent: Sunday, April 22, 2018 6:42 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: CDC Commentary for a June Vital Signs on Suicide

Dear Deb Stone,
I have discussed the editorial with another editor because I was not convinced it was publishable and the assessment was not positive either.
I am very sorry to disappoint you this time.
Sincerely,
Alfredo Morabia, MD, PhD
Editor-in-Chief, AJPH
Twitter | AJPH | Podcast

From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Sent: Thursday, April 19, 2018 4:41 PM
To: American Journal of Public Health Editor
Subject: RE: CDC Commentary for a June Vital Signs on Suicide

Dear Dr. Morabia,

Thank you for your support of our CDC Vital Signs. My colleague, Dr. Eric Caine from the University of Rochester, NY submitted the editorial on April 5th as you requested but to date he has not heard anything back about the status of his submission.

I'm attaching the submission here for your convenience. Any guidance you can provide to keep this on track for a June 7th release would be so appreciated.

Sincerely,

Deb Stone

From: American Journal of Public Health Editor <editorajph@qc.cuny.edu>
Sent: Monday, February 19, 2018 2:56 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: CDC Commentary for a June Vital Signs on Suicide

Dear Deb Stone,

I am happy to offer an opinion editorial in AJPH to accompany the Vital Signs.
If I get it by April 5 it could appear online a few days after June 5 2018.

Sincerely,

Alfredo Morabia, MD, PhD
Editor-in-Chief, AJPH
Twitter | AJPH

From: Morabia, Alfredo <am52@cumc.columbia.edu>
Sent: Thursday, February 15, 2018 11:41 PM
To: American Journal of Public Health Editor
Subject: Fw: CDC Commentary for a June Vital Signs on Suicide

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From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Sent: Thursday, February 15, 2018 5:57 PM
To: am52@columbia.edu
Cc: Preventive.Medicine@qc.cuny.edu
Subject: CDC Commentary for a June Vital Signs on Suicide

Dear Dr. Morabia,

My name is Deb Stone. I'm a behavioral scientist at CDC in the Division of Violence Prevention. I am leading the publication of a CDC Vital Signs focused on suicide to be released **June 5, 2018.** *Vital Signs*, as you may know, began in 2010 and is a high profile monthly CDC publication widely distributed to highlight important public health threats and what can be done to prevent them. The release always includes a web page, an MMWR article, a translation piece (i.e. fact sheet), science clips, and a telebriefing by the CDC Director with the media. It also often includes a companion commentary piece in a top tier journal, linked on our CDC Vital Signs web site and referenced in the other materials.

I am writing to inquire whether AJPH may be interested in collaborating with us to publish such a commentary. The commentary intends to integrate our study findings and the work of

one state that is pioneering the first-ever comprehensive community-based public health approach to suicide prevention.

I believe that both the *Vital Signs* article and the journal companion piece will attract a great deal of attention. This is the debut feature on suicide in a Vital Signs and the results are highly compelling and relevant to a wide public health audience (see description below) including states, prevention practitioners, and providers. In addition, the U.S. Surgeon General has also expressed interest in conducting a town hall meeting as part of the wider release.

BRIEF DESCRIPTION: Suicide rates have increased nearly 30% between 1999 and 2016. To address this serious and growing problem, the proposed *Vital Signs* will use data from the *National Vital Statistics System* (NVSS, 1999-2016) and *National Violent Death Reporting System* (NVDRS, 2015). The trends in suicide rates in the U.S. overall and *by state* and sex, will be reported for the first time. Changes in state rankings over time will also be included. To help the reader fully understand and appreciate the multiple factors influencing suicide risk, the report will also compare the many social and environmental circumstances preceding suicide among people with and without known mental health problems. Preventive solutions will be offered that focus on a comprehensive population-based approach using the best available evidence as described in the CDC's Suicide Prevention Technical Package.

We have selected *AJPH* as our journal of choice for this commentary as we believe its reputation for high quality science and public health prevention most closely aligns with our message and our target audience. We hope that you will partner with us as we forge this exciting territory.

For your convenience, here is an example of a relatively recent Vital Signs (on opioids) and the companion commentary.

I look forward to your reply and the opportunity to provide additional information.

Sincerely,

Deb Stone

Deb Stone, ScD, MSW, MPH
Behavioral Scientist
Suicide, Youth Violence, and Elder Maltreatment Team
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Research & Evaluation Branch
4770 Buford Highway, MS F-64
Atlanta, GA 30341
770.488.3942
dstone3@cdc.gov

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 10:14:12 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Peeples, Amy B. (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Bartholow, Brad (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC);Watkins, Jacqueline (CDC/OID/NCEZID);Royster, Arlethia Elizabeth (CDC/OPHSS/CSELS/DPHID);Cyril, Melissa R. (CDC/ONDIEH/NCIPC)
Cc: CDC ONDIEH NCIPC OC
Subject: FW: CDC Press Release: Suicide rates rising across the U.S. *Embargoed Until 1 P.M. EDT, Thursday, June 7, 2018*
Attachments: PressMaterials_VitalSigns_Suicide_060718.zip
Importance: High

FYI…Vital Signs press release went out this morning.

From: Media@cdc.gov (CDC)
Sent: Thursday, June 7, 2018 9:02 AM
To: Media@cdc.gov (CDC)
Subject: CDC Press Release: Suicide rates rising across the U.S. *Embargoed Until 1 P.M. EDT, Thursday, June 7, 2018*
Importance: High

Press Release

Embargoed until 1:00 pm ET
Thursday, June 7, 2018

Contact: CDC Media Relations
404-639-3286

Suicide rates rising across the U.S.

Comprehensive prevention goes beyond a focus on mental health concerns

Suicide rates have been rising in nearly every state, according to the latest *Vital Signs* report by the Centers for Disease Control and Prevention (CDC). In 2016, nearly 45,000 Americans age 10 or older died by suicide. Suicide is the 10th leading cause of death and is one of just three leading causes that are on the rise.

Suicide is rarely caused by a single factor. Although suicide prevention efforts largely focus on identifying and providing treatment for people with mental health conditions, there are many additional opportunities for prevention.

"Suicide is a leading cause of death for Americans – and it's a tragedy for families and communities across the country," said CDC Principal Deputy Director Anne Schuchat, M.D. "From individuals and communities to employers and healthcare professionals, everyone can play a role in efforts to help save lives and reverse this troubling rise in suicide."

Many factors contribute to suicide

For this *Vital Signs* report, CDC researchers examined state-level trends in suicide rates from 1999-2016. In addition, they used 2015 data from CDC's National Violent Death Reporting System, which covered 27 states, to look at the circumstances of suicide among people with and without known mental health conditions.

Researchers found that more than half of people who died by suicide did *not* have a known diagnosed mental health condition at the time of death. Relationship problems or loss, substance misuse; physical health problems; and job, money, legal or housing stress often contributed to risk for suicide. Firearms were the most common method of suicide used by those with and without a known diagnosed mental health condition.

State suicide rates vary widely

The most recent overall suicide rates (2014-2016) varied four-fold; from 6.9 per 100,000 residents per year in Washington, D.C. to 29.2 per 100,000 residents in Montana.

Across the study period, rates increased in nearly all states. Percentage increases in suicide rates ranged from just under 6 percent in Delaware to over 57 percent in North Dakota. Twenty-five states had suicide rate increases of more than 30 percent.

Wide range of prevention activities needed

The report recommends that states take a comprehensive public health approach to suicide prevention and address the range of factors contributing to suicide. This requires coordination and cooperation from every sector of society: government, public health, healthcare, employers, education, media and community organizations.

To help states with this important work, in 2017 CDC released a technical package on suicide prevention that describes strategies and approaches based on the best available evidence. This can help inform states and communities as they make decisions about prevention activities and priorities.

Everyone can help prevent suicide:

- Learn the warning signs of suicide to identify and appropriately respond to people at risk. Find out how this can save a life by visiting: www.BeThe1to.com
- Reduce access to lethal means – such as medications and firearms – among people at risk of suicide.
- Contact the National Suicide Prevention Lifeline for help: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org

The media can avoid increasing risk when reporting on suicide by:

- Following and sharing recommendations available at www.reportingonsuicide.org (for example, avoiding dramatic headlines or explicit details on suicide methods);
- Providing information on suicide warning signs and suicide prevention resources; and

- Sharing stories of hope and healing.

Vital Signs is a CDC report that typically appears on the first Tuesday of the month as part of the CDC journal *Morbidity and Mortality Weekly Report*. The report provides the latest data and information on key health indicators, and what can be done to drive down these health threats.

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U.S. Department of Health and Human Services

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Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

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Abstract

Introduction: Suicide rates in the United States have risen nearly 30% since 1999, and mental health conditions are one of several factors contributing to suicide. Examining state-level trends in suicide and the multiple circumstances contributing to it can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among persons aged ≥10 years, by state and sex, across six consecutive 3-year periods (1999–2016), were assessed using data from the National Vital Statistics System for 50 states and the District of Columbia. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health conditions.

Results: During 1999–2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases >30%. Rates increased significantly among males and females in 34 and 43 states, respectively. Fifty-four percent of decedents in 27 states in 2015 did not have a known mental health condition. Among decedents with available information, several circumstances were significantly more likely among those without known mental health conditions than among those with mental health conditions, including relationship problems/loss (45.1% versus 39.6%), life stressors (50.5% versus 47.2%), and recent/impending crises (32.9% versus 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states during 1999–2016. Various circumstances contributed to suicides among persons with and without known mental health conditions.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends and family members in the aftermath of a suicide.

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Introduction

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (*1*). From 1999 to 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (*2,3*). Suicide rates have also increased among persons in all age groups <75 years, with adults aged 45–64 having the largest absolute rate increase (from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (232,108) during the same period (*1,3*). Suicide is the tenth leading cause of death and is one of just three leading causes that are increasing (*1,4*). In addition, rates of emergency department visits for nonfatal self-harm, a main risk factor for suicide, increased 42% from 2001 to 2016 (*1*). Together, suicides and self-harm injuries cost the nation approximately $70 billion per year in direct medical and work loss costs (*1*).

The National Strategy for Suicide Prevention (*5*) calls for a public health approach to suicide prevention with efforts spanning multiple levels (individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is determined by multiple factors. Despite this call to action, suicide prevention largely focuses on identifying and referring suicidal persons to mental health treatment and preventing reattempts (*6*). In addition to mental health conditions and prior suicide attempts, other contributing circumstances include social and economic problems, access to lethal means (e.g., substances, firearms) among persons at risk, and poor coping and problem-solving skills (*5*). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them can help reach the national goal, established by the National Action Alliance of Suicide Prevention and the American Foundation for Suicide Prevention, of reducing the annual suicide rate 20% by 2025 (*7*). To assist states in achieving this goal, CDC analyzed state-specific trends in suicide rates and assessed the multiple contributing factors to suicide; this report presents options for strategies to include in comprehensive suicide prevention efforts that are based on the best available evidence.

Methods

Suicide rates were analyzed for persons aged ≥10 years because determining suicidal intent in younger children can be difficult (*8*). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases, Tenth Revision,* underlying-cause-of death codes X60–X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive 3-year aggregate periods spanning 1999–2016 (1999–2001; 2002–2004; 2005–2007; 2008–2010; 2011–2013; and 2014–2016). Rate estimates were age-adjusted to the U.S. 2000 standard population and expressed

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per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same 3-year data aggregates, employing weighted least-squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes.

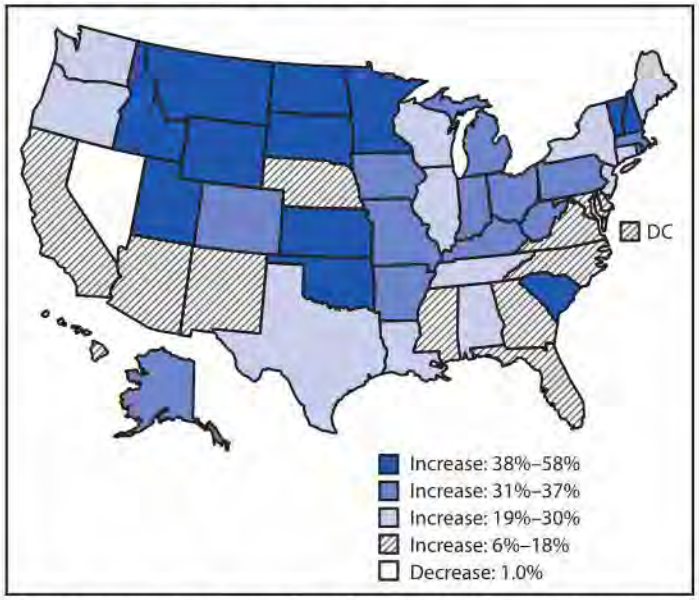
Characteristics of persons aged ≥10 years who died by suicide, with and without known mental health conditions, and the circumstances surrounding the suicides were compared in the 27 states* with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines mental health conditions as disorders and syndromes listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*9*), with the exception of problematic alcohol use and other substance use that are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. A range of circumstances (relationship problems, life stressors, and recent or impending crises) have been identified as potential risk factors for suicide in NVDRS. Circumstances captured are those identified as contributing to suicide in coroner/medical examiner or law enforcement reports, which reflect information provided by family and friends at the time of death. Decedents could have experienced multiple circumstances. Decedents with and without known mental health conditions were compared using chi-square tests. Logistic regression analyses were used to estimate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), controlling for sex, age group, and race/ethnicity.

Results

The most recent overall suicide rates (representing 2014–2016) varied fourfold, from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Across the study period, rates increased in all states except Nevada (where the rate was consistently high throughout the study period), with absolute increases ranging from 0.8 per 100,000 (Delaware) to 8.1 (Wyoming). Percentage increases in rates ranged from 5.9% (Delaware) to 57.6% (North Dakota), with increases >30% observed in 25 states (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785) (Figure).

Modeled suicide rate trends indicated significant increases in 44 states, among males (34 states) and females (43 states), as well as for the United States overall (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Nationally, the model-estimated average annual percentage change for the overall suicide rate was an increase of 1.5%. By sex, estimated national rate trends further indicated significant average annual percentage change increases for males (1.1%) and females (2.6%) (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785).

FIGURE. Percent change in annual suicide rate,* by state — United States, from 1999–2001 to 2014–2016



* Per 100,000 population, age-adjusted to the 2000 U.S. standard population.

Suicide decedents without known mental health conditions (11,039; 54.0%) were compared with those with known mental health conditions (9,407; 46.0%) for 27 states. Whereas decedents were predominantly male (76.8%) (Table 1) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely to be male (83.6% versus 68.8%; odds ratio [OR] = 2.3, 95% CI = 2.2–2.5) and belong to a racial/ethnic minority (OR range = 1.2–2.0). Suicide decedents without known mental health conditions also had significantly higher odds of perpetrating homicide followed by suicide (aOR = 2.9, 95% CI = 2.2–3.8). Among decedents aged ≥18 years, 20.1% of those without known mental health conditions and 15.3% of those with mental health conditions had previously served in the U.S. military or were serving at the time of death.

Whereas firearms were the most common method of suicide overall (48.5%), decedents without known mental health conditions were more likely to die by firearm (55.3%) and less likely to die by hanging/strangulation/suffocation (26.9%) or poisoning (10.4%) than were those with known mental health conditions (40.6%, 31.3%, and 19.8%, respectively). These differences remained significant in the adjusted models.

Toxicology testing was less likely to be performed for decedents without known mental health conditions. Among those with toxicology results, decedents without known mental health

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

TABLE 1. Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	**15,702 (76.8)**	6,469 (68.8)	9,233 (83.6)	<0.01	2.3 (2.2–2.5)	NA
Female	**4,744 (23.2)**	2,938 (31.2)	1,806 (16.4)	<0.01	0.4 (0.4–0.5)	NA
Age group (yrs)**						
10–24	**2,804 (13.7)**	1,211 (12.9)	1,593 (14.4)	<0.01	1.1 (1.1–1.2)	NA
25–44	**6,456 (31.6)**	3,036 (32.3)	3,420 (31.0)	<0.05	0.9 (0.9–1.0)	NA
45–64	**7,718 (37.7)**	3,820 (40.6)	3,898 (35.3)	<0.01	0.8 (0.8–0.8)	NA
≥65	**3,468 (17.0)**	1,340 (14.2)	2,128 (19.3)	<0.01	1.4 (1.3–1.5)	NA
Race/Ethnicity						
White, non-Hispanic	**17,102 (83.6)**	8,165 (86.8)	8,937 (81.0)	<0.01	0.6 (0.6–0.7)	NA
Black, non-Hispanic	**1,228 (6.0)**	411 (4.4)	817 (7.4)	<0.01	1.7 (1.5–2.0)	NA
American Indian/Alaska Native, non-Hispanic	**378 (1.8)**	112 (1.2)	266 (2.4)	<0.01	2.0 (1.6–2.6)	NA
Asian, non-Hispanic	**576 (2.8)**	235 (2.5)	341 (3.1)	<0.05	1.2 (1.1–1.5)	NA
Hispanic	**1,096 (5.4)**	463 (4.9)	633 (5.7)	<0.05	1.2 (1.0–1.3)	NA
Other	**66 (0.3)**	21 (0.2)	45 (0.4)	<0.05	1.8 (1.1–3.1)	NA
Extended demographics						
Ever served in military††	**3,429 (17.8)**	1,354 (15.3)	2,075 (20.1)	<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	**240 (1.2)**	104 (1.1)	136 (1.3)	NS	1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident type						
Single suicide	**20,063 (98.2)**	9,318 (99.1)	10,745 (97.4)	<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	**319 (1.6)**	64 (0.7)	255 (2.3)	<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	**64 (0.3)**	25 (0.3)	39 (0.4)	NS	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	**9,909 (48.5)**	3,821 (40.6)	6,088 (55.3)	<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	**5,907 (28.9)**	2,940 (31.3)	2,967 (26.9)	<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	**3,003 (14.7)**	1,861 (19.8)	1,142 (10.4)	<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	**1,021 (34.0)**	666 (35.8)	355 (31.1)	<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	**944 (31.4)**	608 (32.7)	336 (29.4)	NS	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	**800 (26.6)**	644 (34.6)	156 (13.7)	<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	**624 (20.8)**	468 (25.1)	156 (13.7)	<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	**219 (7.3)**	195 (10.5)	24 (2.1)	<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	**1,595 (7.8)**	780 (8.3)	815 (7.4)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)

See table footnotes on next page.

conditions were less likely to test positive for any substance overall (aOR = 0.8, 95% CI = 0.7–0.8), including opioids (aOR = 0.90, 95% CI = 0.81–0.99), but were more likely to test positive for alcohol (aOR = 1.2, 95%, CI = 1.1–1.3).

Information on circumstances surrounding suicide were available for all decedents with mental health conditions (9,407) and approximately 85% of those without known mental health conditions (9,357) in 27 states (Table 2). Persons without known mental health conditions were less likely to have any problematic substance use (aOR = 0.7, 95% CI = 0.7–0.8) than were persons with known mental health conditions. Whereas two thirds of decedents with known mental health conditions had a history of mental health or substance use treatment (67.2%), just over half (54.0%) were in treatment at the time of death.

Decedents without known mental health conditions had a significantly higher likelihood of any relationship problem/loss (45.1%) than did those with known mental health conditions (39.6%), specifically intimate partner problems (30.2% versus 24.1%), arguments/conflicts (17.5% versus 13.6%), and perpetrating interpersonal violence in the past month (3.0% versus 1.4%). Decedents without known mental health conditions were also more likely than were those with known mental health conditions to have experienced any life stressors (50.5% versus 47.2%) such as recent criminal legal problems (10.7% versus 6.2%) or eviction/loss of home (4.3% versus 3.4%) and were more likely to have had a recent or impending (within the preceding or upcoming 2 weeks, respectively) crisis (a current or acute event thought to contribute to the suicide) (32.9% versus 26.0%). All of these differences remained significant in the adjusted models. Physical health problems and job/financial problems were commonly contributing stressors among both persons without mental health conditions (23.2% and 15.6%, respectively) and those with mental health conditions (21.4%

TABLE 1. (*Continued*) Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Toxicology results						
Any toxicology testing	**13,317 (65.1)**	6,658 (70.8)	6,659 (60.3)	<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	**9,913 (74.4)**	5,192 (78.0)	4,721 (70.9)	<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected* **						
Alcohol						
Tested	**10,950 (53.6)**	5,409 (57.5)	5,541 (50.2)	<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	**4,442 (40.6)**	2,115 (39.1)	2,327 (42.0)	<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	**8,554 (41.8)**	4,258 (45.3)	4,296 (38.9)	<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	**2,279 (26.6)**	1,238 (29.1)	1,041 (24.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	**8,124 (39.7)**	4,226 (44.9)	3,898 (35.3)	<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	**2,464 (30.3)**	1,639 (38.8)	825 (21.2)	<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	**7,978 (39.0)**	3,866 (41.1)	4,112 (37.2)	<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	**499 (6.3)**	216 (5.6)	283 (6.9)	<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	**7,615 (37.2)**	3,696 (39.3)	3,919 (35.5)	<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	**736 (9.7)**	376 (10.2)	360 (9.2)	NS	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	**6,569 (32.1)**	3,127 (33.2)	3,442 (31.2)	<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	**1,471 (22.4)**	710 (22.7)	761 (22.1)	NS	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	**5,425 (26.5)**	3,103 (33.0)	2,322 (21.0)	<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	**2,214 (40.8)**	1,735 (55.9)	479 (20.6)	<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviations: CI = confidence interval; NA = not adjusted; NS = not significant; OR = odds ratio.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology testing.

*** Denominator for each positive group is the number tested for the substance in that group.

and 16.8%, respectively). Similarly, among all persons with recent crises, intimate partner problems were the most common types and did not differ by group.

Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR = 0.5, 95% CI = 0.4–0.5). Among those recently released, decedents without known mental health conditions were significantly more likely than decedents with mental health conditions to have been released from a correctional facility (25.7% versus 8.7%), hospital (43.7% versus 33.0%), or other facility, such as an alcohol/substance use treatment facility (24.2% versus 11.6%). Among decedents with known mental health conditions who were recently released from an institution, 46.7% were released from psychiatric facilities.

Decedents without known mental health conditions were significantly less likely to have a history of suicidal ideation (23.0%) or prior suicide attempts (10.3%) compared with those with known mental health conditions (40.8% and 29.4%, respectively). Suicide intent was disclosed by 22.4% and 24.5% of persons without and with known mental health conditions, respectively.

Conclusions and Comments

During 1999–2016, suicide rates increased significantly in 44 states, and 25 states experienced increases >30%. Rates increased significantly among males in 34 states, and females in 43 states. Additional research into the specific causes of these trends is needed. Data from the 27 states participating in NVDRS provide important insight into circumstances surrounding suicide and can help states identify prevention priorities.

TABLE 2. Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	**18,764 (91.8)**	9,407 (100)	9,357 (84.8)	<0.01	N/A	N/A
Mental health						
Any current diagnosed mental health condition**						
Depression/Dysthymia	—††	7,076 (75.2)	N/A	N/A	N/A	N/A
Anxiety disorder	—††	1,579 (16.8)	N/A	N/A	N/A	N/A
Bipolar disorder	—††	1,431 (15.2)	N/A	N/A	N/A	N/A
Schizophrenia	—††	509 (5.4)	N/A	N/A	N/A	N/A
PTSD	—††	424 (4.5)	N/A	N/A	N/A	N/A
ADD/ADHD	—††	226 (2.4)	N/A	N/A	N/A	N/A
Not specified	—††	760 (8.1)	N/A	N/A	N/A	N/A
Current depressed mood§§	**7,038 (37.5)**	3,962 (42.1)	3,076 (32.9)	<0.01	0.7 (0.6–0.7)	0.7 (0.6–0.7)
Problematic substance use						
Any	**5,319 (28.3)**	2,976 (31.6)	2,343 (25.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Alcohol	**3,268 (17.4)**	1,862 (19.8)	1,406 (15.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Other	**3,084 (16.4)**	1,768 (18.8)	1,316 (14.1)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Treatment						
Current mental health/substance use treatment	**5,141 (27.4)**	5,077 (54.0)	64 (0.7)	<0.01	0.01 (0.01–0.01)	0.01 (0.01–0.01)
Ever treated for mental health/substance disorder	**6,717 (35.8)**	6,323 (67.2)	394 (4.2)	<0.01	0.02 (0.02–0.02)	0.02 (0.02–0.03)
Relationship problems/loss						
Any relationship problem/loss	**7,948 (42.4)**	3,726 (39.6)	4,222 (45.1)	<0.01	1.3 (1.2–1.3)	1.3 (1.2–1.4)
Intimate partner problem	**5,098 (27.2)**	2,270 (24.1)	2,828 (30.2)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Perpetrator of interpersonal violence in past month	**414 (2.2)**	131 (1.4)	283 (3.0)	<0.01	2.2 (1.8–2.7)	2.0 (1.6–2.4)
Victim of interpersonal violence in past month	**84 (0.4)**	53 (0.6)	31 (0.3)	<0.05	0.6 (0.4–0.9)	0.8 (0.5–1.2)
Family relationship problem	**1,671 (8.9)**	873 (9.3)	798 (8.5)	NS	0.9 (0.8–1.0)	1.0 (0.9–1.1)
Other relationship problem (nonintimate)	**403 (2.1)**	202 (2.1)	201 (2.1)	NS	1.0 (0.8–1.2)	1.1 (0.9–1.3)
Argument or conflict (not specified)	**2,914 (15.5)**	1,278 (13.6)	1,636 (17.5)	<0.01	1.3 (1.2–1.5)	1.4 (1.3–1.5)
Death of a loved one (any)	**1,497 (8.0)**	826 (8.8)	671 (7.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–0.9)
Nonsuicide death	**1,181 (6.3)**	647 (6.9)	534 (5.7)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Suicide of family or friend	**379 (2.0)**	217 (2.3)	162 (1.7)	<0.01	0.7 (0.6–0.9)	0.8 (0.7–1.0)
Other life stressors						
Any life stressor	**9,171 (48.9)**	4,442 (47.2)	4,729 (50.5)	<0.01	1.1 (1.1–1.2)	1.1 (1.0–1.2)
Recent criminal legal problem	**1,588 (8.5)**	586 (6.2)	1,002 (10.7)	<0.01	1.8 (1.6–2.0)	1.7 (1.5–1.9)
Other legal problem	**748 (4.0)**	378 (4.0)	370 (4.0)	NS	1.0 (0.8–1.1)	1.0 (0.9–1.2)
Physical health problem	**4,179 (22.3)**	2,012 (21.4)	2,167 (23.2)	<0.01	1.1 (1.0–1.2)	1.0 (1.0–1.1)
Job/Financial problem¶¶	**2,941 (16.2)**	1,530 (16.8)	1,411 (15.6)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Eviction or loss of home	**722 (3.8)**	317 (3.4)	405 (4.3)	<0.01	1.3 (1.1–1.5)	1.4 (1.2–1.6)
School problem***	**162 (19.9)**	70 (17.8)	92 (21.9)	NS	1.3 (0.9–1.8)	1.3 (0.9–1.9)
Recent release from an institution†††	**1,412 (7.6)**	941 (10.2)	471 (5.1)	<0.01	0.5 (0.4–0.5)	0.5 (0.4–0.5)
Jail/Prison/Detention facility	**203 (14.4)**	82 (8.7)	121 (25.7)	<0.01	3.6 (2.7–4.9)	4.5 (3.2–6.4)
Hospital	**517 (36.6)**	311 (33.0)	206 (43.7)	<0.01	1.6 (1.3–2.0)	1.3 (1.0–1.7)
Psychiatric hospital/institution	**469 (33.2)**	439 (46.7)	30 (6.4)	<0.01	0.1 (0.1–0.1)	0.1 (0.1–0.1)
Other (includes alcohol/SU treatment facilities)	**223 (15.8)**	109 (11.6)	114 (24.2)	<0.01	2.4 (1.8–3.3)	2.5 (1.8–3.3)

See table footnotes on next page.

Suicidologists regularly state that suicide is not caused by a single factor (*5*); however, suicide prevention is often oriented toward mental health conditions alone with regard to downstream identification of suicidal persons, treatment of mental health conditions, and prevention of reattempts. This study found that approximately half of suicide decedents in NVDRS did not have a known mental health condition, indicating that additional focus on nonmental health factors further upstream could provide important information for a public health approach (*10*). Those without a known mental health condition suffered more from relationship problems and other life stressors such as criminal/legal matters, eviction/loss of home, and recent or impending crises.

Similarly, persons with mental health conditions also often experienced other circumstances such as relationship problems and job/financial or physical health problems that contributed to their suicide. These findings point to the need to both prevent the circumstances associated with the onset of mental health conditions and support persons with known mental health conditions to decrease their risk for poor outcomes (*11*). Two thirds of suicide decedents with mental health conditions had a history of treatment for mental health or substance use disorders,

TABLE 2. (*Continued*) Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Crisis within past or upcoming 2 weeks§§§	**5,525 (29.4)**	2,444 (26.0)	3,081 (32.9)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Intimate partner problem	**1,968 (35.6)**	854 (34.9)	1,114 (36.2)	NS	1.1 (0.9–1.2)	1.1 (0.9–1.2)
Physical health problem	**739 (13.4)**	315 (12.9)	424 (13.8)	NS	1.1 (0.9–1.3)	1.0 (0.8–1.2)
Criminal legal problem	**621 (11.2)**	203 (8.3)	418 (13.6)	<0.01	1.7 (1.5–2.1)	1.6 (1.3–1.9)
Family relationship problem	**430 (7.8)**	212 (8.7)	218 (7.1)	<0.05	0.8 (0.7–1.0)	0.9 (0.7–1.1)
Job problem	**354 (6.4)**	191 (7.8)	163 (5.3)	<0.01	0.7 (0.5–0.8)	0.7 (0.5–0.8)
Suicide event/history						
Left a note	**6,468 (34.5)**	3,182 (33.8)	3,286 (35.1)	NS	1.1 (1.0–1.1)	1.2 (1.1–1.2)
Disclosed suicide intent	**4,405 (23.5)**	2,306 (24.5)	2,099 (22.4)	<0.01	0.9 (0.8–1.0)	0.9 (0.8–0.9)
History of ideation	**5,990 (31.9)**	3,838 (40.8)	2,152 (23.0)	<0.01	0.4 (0.4–0.5)	0.4 (0.4–0.5)
History of attempts	**3,732 (19.9)**	2,770 (29.4)	962 (10.3)	<0.01	0.3 (0.3–0.3)	0.3 (0.3–0.3)

Abbreviations: ADD/ADHD = attention deficit disorder/attention deficit hyperactivity disorder; CI = confidence interval; N/A = not applicable; NS = not significant; OR = odds ratio; PTSD = posttraumatic stress disorder; SU = substance use.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was the reference group.

** Includes decedents with one or more diagnosed current mental health conditions, which are not mutually exclusive. Therefore, sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health conditions.

†† The specific type of mental health condition was calculated only among those with one or more known diagnosed mental health conditions.

§§ Not a diagnosis.

¶¶ Denominator is decedents aged ≥18 years.

*** Denominator is decedents aged 10–18 years.

††† Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.

§§§ Denominator of crisis subgroup is decedents with any crisis within past or upcoming 2 weeks. Crises depicted here represent the most commonly occurring categories.

with approximately half in treatment when they died. This finding suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities, such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. In addition, increased access to behavioral health providers in underserved areas is needed, as is expansion of health care systems that integrate physical and behavioral health, with a priority on suicide prevention and patient safety, especially through care transitions (*12*).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belonging and access to informational, tangible, emotional, and social support; and identifying and better supporting persons at risk (e.g., military veterans, persons with physical/mental health conditions) (*12*). Other strategies include creating protective environments (e.g., reducing access to lethal means among persons at risk for suicide, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for persons with mental health conditions and other life challenges), strengthening access to and delivery of care, supporting family and friends after a suicide, and encouraging the media to follow safe reporting recommendations (*12*). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (*10*).

The findings in this report are subject to at least three limitations. First, in the state-level analysis, rankings for four states (Maryland, Massachusetts, Rhode Island, and Utah) might have been affected by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward) or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml). Finally, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies that include more in-depth interviews with next-of-kin often identify greater attributions to mental health disorders

Summary

What is already known about this topic?

In 2016, nearly 45,000 persons died by suicide in the United States. Mental health conditions are one of several contributors to suicide.

What is added by this report?

During 1999–2016, suicide rates increased in nearly every state, including >30% increases in 25 states. 2015 data from 27 states indicate 54% of suicide decedents were not known to have mental health conditions. Relationship, substance use, health, and job or financial problems are among the other circumstances contributing to suicide.

What are the implications for public health practice?

A comprehensive approach using proven prevention strategies, such as those in CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, can help reach the national goal of reducing the annual suicide rate 20% by 2025.

(*13*); however, many methodological variations across studies exist (*14*). It is likely that some persons without known mental health conditions in the current study were experiencing mental health challenges that were unknown, undiagnosed, or not reported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (*12*) to better understand suicide in their populations, prioritize evidence-based comprehensive suicide prevention, and save lives.

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Conflict of Interest

No conflicts of interest were reported.

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#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



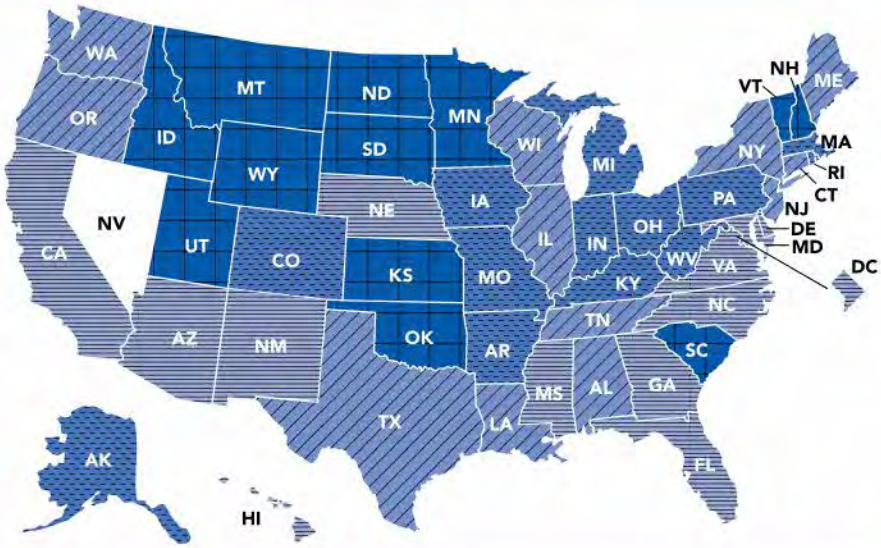
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

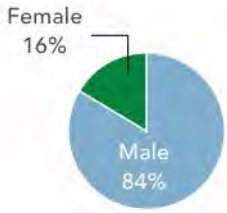


Differences exist among those with and without mental health conditions.

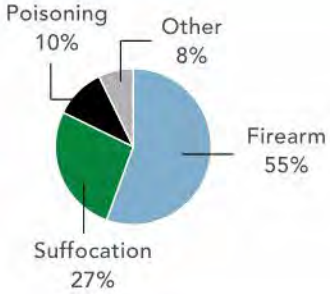
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

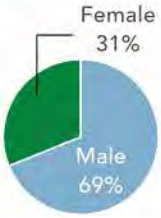


Method

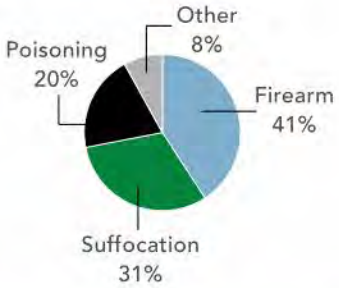


Known mental health conditions

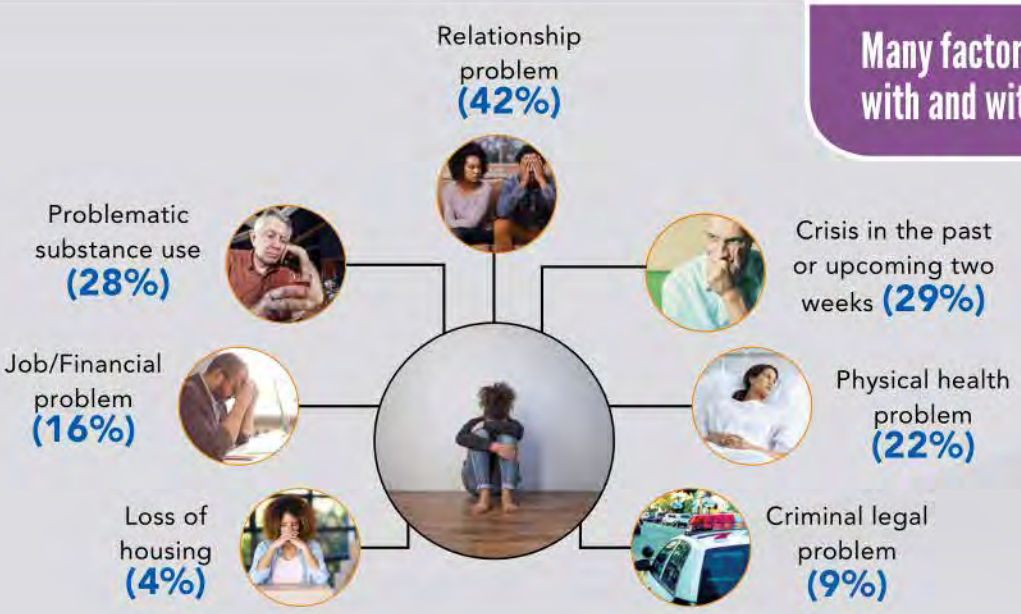
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018

Media Advisory

Embargoed Until 1 p.m. EDT
Thursday, June 7, 2018

Contact: CDC Media Relations
(404) 639-3286

CDC Telebriefing: New *Vital Signs* Report

Nearly 45,000 deaths by suicide in 2016:
What can be done to prevent suicides?

What

According to the latest Vital Signs report, suicide increased in nearly every U.S. state from 1999 through 2016. In addition, suicide rates increased more than 30% in half of states. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death.

Who

CDC Principal Deputy Director Anne Schuchat, MD, RADM, USPHS

When

Thursday, June 7, at 12:00 p.m. ET

Dial-In

Media: 888-795-0855

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If you would like to ask a question during the call, press *1 on your touchtone phone. Press *2 to withdraw your question.

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TRANSCRIPT

A transcript of this media availability will be available following the briefing at CDC's web site: www.cdc.gov/media.

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U.S. Department of Health and Human Services

CDC works 24/7 protecting America's health, safety, and security. Whether diseases start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

Press Release

Embargoed until 1:00 pm ET
Thursday, June 7, 2018

Contact: CDC Media Relations
404-639-3286

Suicide rates rising across the U.S.

Comprehensive prevention goes beyond a focus on mental health concerns

Suicide rates have been rising in nearly every state, according to the latest *Vital Signs* report by the Centers for Disease Control and Prevention (CDC). In 2016, nearly 45,000 Americans age 10 or older died by suicide. Suicide is the 10th leading cause of death and is one of just three leading causes that are on the rise.

Suicide is rarely caused by a single factor. Although suicide prevention efforts largely focus on identifying and providing treatment for people with mental health conditions, there are many additional opportunities for prevention.

"Suicide is a leading cause of death for Americans – and it's a tragedy for families and communities across the country," said CDC Principal Deputy Director Anne Schuchat, M.D. "From individuals and communities to employers and healthcare professionals, everyone can play a role in efforts to help save lives and reverse this troubling rise in suicide."

Many factors contribute to suicide

For this *Vital Signs* report, CDC researchers examined state-level trends in suicide rates from 1999-2016. In addition, they used 2015 data from CDC's National Violent Death Reporting System, which covered 27 states, to look at the circumstances of suicide among people with and without known mental health conditions.

Researchers found that more than half of people who died by suicide did *not* have a known diagnosed mental health condition at the time of death. Relationship problems or loss, substance misuse; physical health problems; and job, money, legal or housing stress often contributed to risk for suicide. Firearms were the most common method of suicide used by those with and without a known diagnosed mental health condition.

State suicide rates vary widely

The most recent overall suicide rates (2014-2016) varied four-fold; from 6.9 per 100,000 residents per year in Washington, D.C. to 29.2 per 100,000 residents in Montana.

Across the study period, rates increased in nearly all states. Percentage increases in suicide rates ranged from just under 6 percent in Delaware to over 57 percent in North Dakota. Twenty-five states had suicide rate increases of more than 30 percent.

Wide range of prevention activities needed

The report recommends that states take a comprehensive public health approach to suicide prevention and address the range of factors contributing to suicide. This requires coordination and cooperation from

every sector of society: government, public health, healthcare, employers, education, media and community organizations.

To help states with this important work, in 2017 CDC released a technical package on suicide prevention that describes strategies and approaches based on the best available evidence. This can help inform states and communities as they make decisions about prevention activities and priorities.

Everyone can help prevent suicide:

- Learn the warning signs of suicide to identify and appropriately respond to people at risk. Find out how this can save a life by visiting: www.BeThe1to.com
- Reduce access to lethal means – such as medications and firearms – among people at risk of suicide.
- Contact the National Suicide Prevention Lifeline for help: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org

The media can avoid increasing risk when reporting on suicide by:

- Following and sharing recommendations available at www.reportingonsuicide.org (for example, avoiding dramatic headlines or explicit details on suicide methods);
- Providing information on suicide warning signs and suicide prevention resources; and
- Sharing stories of hope and healing.

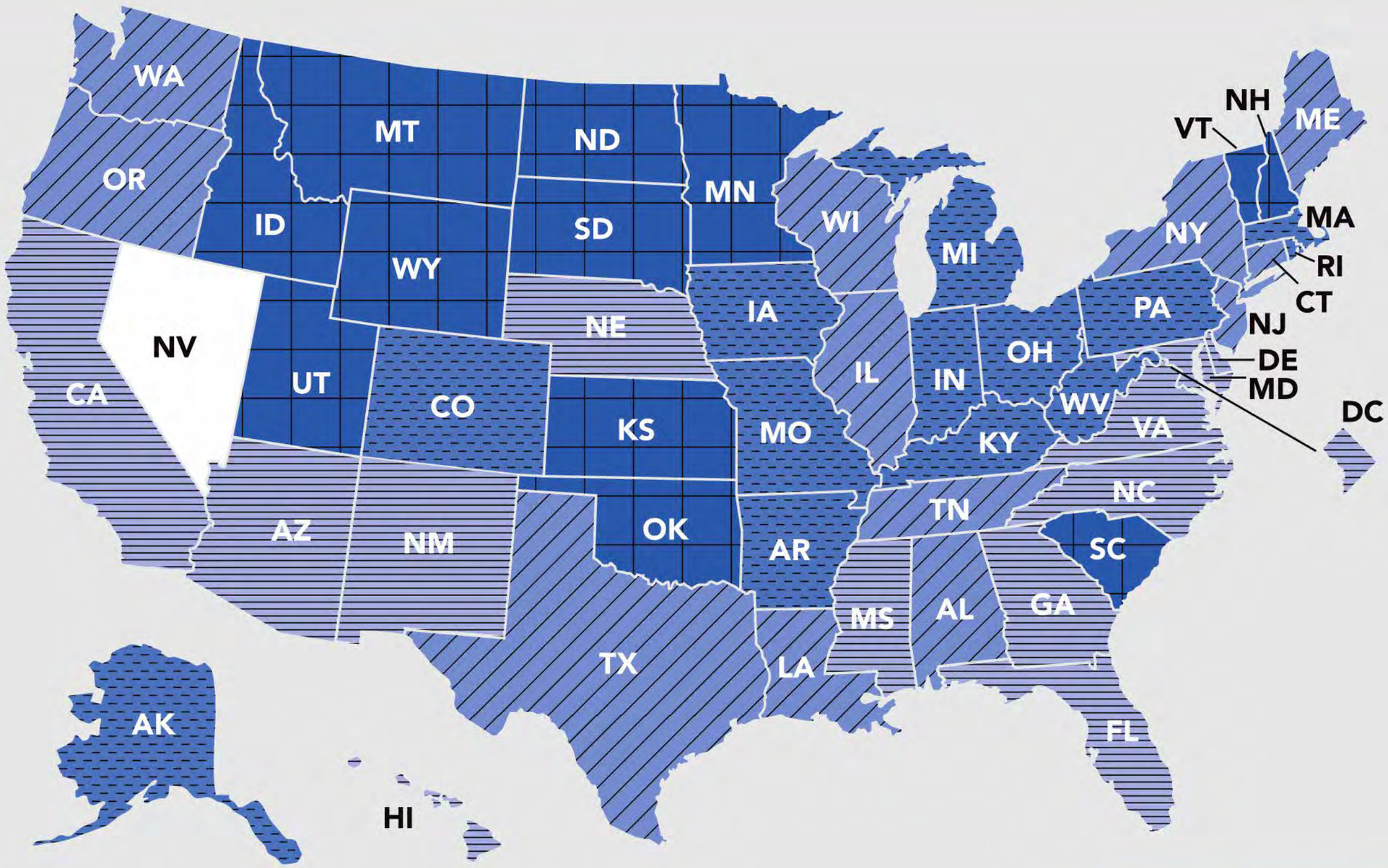
Vital Signs is a CDC report that typically appears on the first Tuesday of the month as part of the CDC journal *Morbidity and Mortality Weekly Report*. The report provides the latest data and information on key health indicators, and what can be done to drive down these health threats.

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U.S. Department of Health and Human Services

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Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System.*

CDC Vitalsigns™

https://www.cdc.gov/vitalsigns/suicide

CS292322-C

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 09:36:28 -0400
To: cmaxwell@suicidology.org
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: FW: CDC Report
Attachments: MMWR_Vital Signs_ Suicide_6.7.2018_article.pdf, MMWR Supplemental table__VS Suicide_ 6.7.2018_final.pdf, FACT SHEET_Vital Signs_June_2018_Suicide_Final_WEB.pdf

Chris,
Thank you very much for reaching out. Deb shared your email with me as I'm helping with outreach related to the Vital Signs launch. Embargoed copies of the report and associated materials are attached. Please do not share this information with your networks until the embargo lifts **at 1pm today.** Some additional information is below on events – telebriefing for media, social media tools and Town Hall teleconference next week.
I'm so sorry we weren't able to share these materials with you sooner so that it would have helped with media inquiries. We were under a strict embargo and are only allowed to share even embargoed copies beginning at this morning. Please let me know if I can answer any questions or help in anyway moving forward.
Best,
Malia

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.
This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpageto find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at

www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).
Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

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Preventing Injuries and Violence
Through Science and Action

From: Chris Maxwell <cmaxwell@suicidology.org>
Sent: Thursday, June 7, 2018 9:27 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: CDC Report

Hi Deb - hope you're doing well!
We've been contacted by some members of the press over the past couple of days due to the recent and unfortunate celebrity suicide and a few of them have been referencing the yet-to-be-released report coming out today regarding suicide and NVDRS data.
Would it be possible for our Executive Director and President to receive drafts or embargoed advance copies of these types of reports so they can be better prepared to answer the questions from the media? This could go a long way in helping both our membership and the general public be more prepared to handle inquiries from the media, especially when the media has been provided advance notice or data.
If we need to contact someone else over there, please let us know who we should get in touch with.
Thanks and looking forward to hearing from you!

Chris Maxwell
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AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 67 / No. 22
June 8, 2018

Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

Deborah M. Stone, ScD[1]; Thomas R. Simon PhD[1]; Katherine A. Fowler, PhD[1]; Scott R. Kegler, PhD[2]; Keming Yuan, MS[1]; Kristin M. Holland, PhD[1]; Asha Z. Ivey-Stephenson, PhD[1]; Alex E. Crosby, MD[1]

Abstract

Introduction: Suicide rates in the United States have risen nearly 30% since 1999, and mental health conditions are one of several factors contributing to suicide. Examining state-level trends in suicide and the multiple circumstances contributing to it can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among persons aged ≥10 years, by state and sex, across six consecutive 3-year periods (1999–2016), were assessed using data from the National Vital Statistics System for 50 states and the District of Columbia. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health conditions.

Results: During 1999–2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases >30%. Rates increased significantly among males and females in 34 and 43 states, respectively. Fifty-four percent of decedents in 27 states in 2015 did not have a known mental health condition. Among decedents with available information, several circumstances were significantly more likely among those without known mental health conditions than among those with mental health conditions, including relationship problems/loss (45.1% versus 39.6%), life stressors (50.5% versus 47.2%), and recent/impending crises (32.9% versus 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states during 1999–2016. Various circumstances contributed to suicides among persons with and without known mental health conditions.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends and family members in the aftermath of a suicide.

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Introduction

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (*1*). From 1999 to 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (*2,3*). Suicide rates have also increased among persons in all age groups <75 years, with adults aged 45–64 having the largest absolute rate increase (from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (232,108) during the same period (*1,3*). Suicide is the tenth leading cause of death and is one of just three leading causes that are increasing (*1,4*). In addition, rates of emergency department visits for nonfatal self-harm, a main risk factor for suicide, increased 42% from 2001 to 2016 (*1*). Together, suicides and self-harm injuries cost the nation approximately $70 billion per year in direct medical and work loss costs (*1*).

The National Strategy for Suicide Prevention (*5*) calls for a public health approach to suicide prevention with efforts spanning multiple levels (individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is determined by multiple factors. Despite this call to action, suicide prevention largely focuses on identifying and referring suicidal persons to mental health treatment and preventing reattempts (*6*). In addition to mental health conditions and prior suicide attempts, other contributing circumstances include social and economic problems, access to lethal means (e.g., substances, firearms) among persons at risk, and poor coping and problem-solving skills (*5*). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them can help reach the national goal, established by the National Action Alliance of Suicide Prevention and the American Foundation for Suicide Prevention, of reducing the annual suicide rate 20% by 2025 (*7*). To assist states in achieving this goal, CDC analyzed state-specific trends in suicide rates and assessed the multiple contributing factors to suicide; this report presents options for strategies to include in comprehensive suicide prevention efforts that are based on the best available evidence.

Methods

Suicide rates were analyzed for persons aged ≥10 years because determining suicidal intent in younger children can be difficult (*8*). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases, Tenth Revision,* underlying-cause-of death codes X60–X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive 3-year aggregate periods spanning 1999–2016 (1999–2001; 2002–2004; 2005–2007; 2008–2010; 2011–2013; and 2014–2016). Rate estimates were age-adjusted to the U.S. 2000 standard population and expressed

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per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same 3-year data aggregates, employing weighted least-squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes.

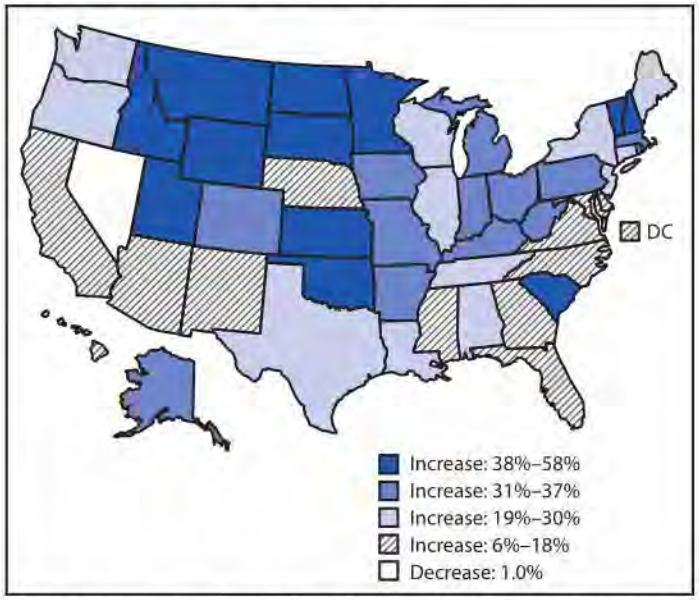
Characteristics of persons aged ≥10 years who died by suicide, with and without known mental health conditions, and the circumstances surrounding the suicides were compared in the 27 states* with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines mental health conditions as disorders and syndromes listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*9*), with the exception of problematic alcohol use and other substance use that are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. A range of circumstances (relationship problems, life stressors, and recent or impending crises) have been identified as potential risk factors for suicide in NVDRS. Circumstances captured are those identified as contributing to suicide in coroner/medical examiner or law enforcement reports, which reflect information provided by family and friends at the time of death. Decedents could have experienced multiple circumstances. Decedents with and without known mental health conditions were compared using chi-square tests. Logistic regression analyses were used to estimate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), controlling for sex, age group, and race/ethnicity.

Results

The most recent overall suicide rates (representing 2014–2016) varied fourfold, from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Across the study period, rates increased in all states except Nevada (where the rate was consistently high throughout the study period), with absolute increases ranging from 0.8 per 100,000 (Delaware) to 8.1 (Wyoming). Percentage increases in rates ranged from 5.9% (Delaware) to 57.6% (North Dakota), with increases >30% observed in 25 states (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785) (Figure).

Modeled suicide rate trends indicated significant increases in 44 states, among males (34 states) and females (43 states), as well as for the United States overall (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Nationally, the model-estimated average annual percentage change for the overall suicide rate was an increase of 1.5%. By sex, estimated national rate trends further indicated significant average annual percentage change increases for males (1.1%) and females (2.6%) (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785).

FIGURE. Percent change in annual suicide rate,* by state — United States, from 1999–2001 to 2014–2016



* Per 100,000 population, age-adjusted to the 2000 U.S. standard population.

Suicide decedents without known mental health conditions (11,039; 54.0%) were compared with those with known mental health conditions (9,407; 46.0%) for 27 states. Whereas decedents were predominantly male (76.8%) (Table 1) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely to be male (83.6% versus 68.8%; odds ratio [OR] = 2.3, 95% CI = 2.2–2.5) and belong to a racial/ethnic minority (OR range = 1.2–2.0). Suicide decedents without known mental health conditions also had significantly higher odds of perpetrating homicide followed by suicide (aOR = 2.9, 95% CI = 2.2–3.8). Among decedents aged ≥18 years, 20.1% of those without known mental health conditions and 15.3% of those with mental health conditions had previously served in the U.S. military or were serving at the time of death.

Whereas firearms were the most common method of suicide overall (48.5%), decedents without known mental health conditions were more likely to die by firearm (55.3%) and less likely to die by hanging/strangulation/suffocation (26.9%) or poisoning (10.4%) than were those with known mental health conditions (40.6%, 31.3%, and 19.8%, respectively). These differences remained significant in the adjusted models.

Toxicology testing was less likely to be performed for decedents without known mental health conditions. Among those with toxicology results, decedents without known mental health

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

TABLE 1. Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	**15,702 (76.8)**	6,469 (68.8)	9,233 (83.6)	<0.01	2.3 (2.2–2.5)	NA
Female	**4,744 (23.2)**	2,938 (31.2)	1,806 (16.4)	<0.01	0.4 (0.4–0.5)	NA
Age group (yrs)**						
10–24	**2,804 (13.7)**	1,211 (12.9)	1,593 (14.4)	<0.01	1.1 (1.1–1.2)	NA
25–44	**6,456 (31.6)**	3,036 (32.3)	3,420 (31.0)	<0.05	0.9 (0.9–1.0)	NA
45–64	**7,718 (37.7)**	3,820 (40.6)	3,898 (35.3)	<0.01	0.8 (0.8–0.8)	NA
≥65	**3,468 (17.0)**	1,340 (14.2)	2,128 (19.3)	<0.01	1.4 (1.3–1.5)	NA
Race/Ethnicity						
White, non-Hispanic	**17,102 (83.6)**	8,165 (86.8)	8,937 (81.0)	<0.01	0.6 (0.6–0.7)	NA
Black, non-Hispanic	**1,228 (6.0)**	411 (4.4)	817 (7.4)	<0.01	1.7 (1.5–2.0)	NA
American Indian/Alaska Native, non-Hispanic	**378 (1.8)**	112 (1.2)	266 (2.4)	<0.01	2.0 (1.6–2.6)	NA
Asian, non-Hispanic	**576 (2.8)**	235 (2.5)	341 (3.1)	<0.05	1.2 (1.1–1.5)	NA
Hispanic	**1,096 (5.4)**	463 (4.9)	633 (5.7)	<0.05	1.2 (1.0–1.3)	NA
Other	**66 (0.3)**	21 (0.2)	45 (0.4)	<0.05	1.8 (1.1–3.1)	NA
Extended demographics						
Ever served in military††	**3,429 (17.8)**	1,354 (15.3)	2,075 (20.1)	<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	**240 (1.2)**	104 (1.1)	136 (1.3)	NS	1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident type						
Single suicide	**20,063 (98.2)**	9,318 (99.1)	10,745 (97.4)	<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	**319 (1.6)**	64 (0.7)	255 (2.3)	<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	**64 (0.3)**	25 (0.3)	39 (0.4)	NS	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	**9,909 (48.5)**	3,821 (40.6)	6,088 (55.3)	<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	**5,907 (28.9)**	2,940 (31.3)	2,967 (26.9)	<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	**3,003 (14.7)**	1,861 (19.8)	1,142 (10.4)	<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	**1,021 (34.0)**	666 (35.8)	355 (31.1)	<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	**944 (31.4)**	608 (32.7)	336 (29.4)	NS	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	**800 (26.6)**	644 (34.6)	156 (13.7)	<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	**624 (20.8)**	468 (25.1)	156 (13.7)	<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	**219 (7.3)**	195 (10.5)	24 (2.1)	<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	**1,595 (7.8)**	780 (8.3)	815 (7.4)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)

See table footnotes on next page.

conditions were less likely to test positive for any substance overall (aOR = 0.8, 95% CI = 0.7–0.8), including opioids (aOR = 0.90, 95% CI = 0.81–0.99), but were more likely to test positive for alcohol (aOR = 1.2, 95%, CI = 1.1–1.3).

Information on circumstances surrounding suicide were available for all decedents with mental health conditions (9,407) and approximately 85% of those without known mental health conditions (9,357) in 27 states (Table 2). Persons without known mental health conditions were less likely to have any problematic substance use (aOR = 0.7, 95% CI = 0.7–0.8) than were persons with known mental health conditions. Whereas two thirds of decedents with known mental health conditions had a history of mental health or substance use treatment (67.2%), just over half (54.0%) were in treatment at the time of death.

Decedents without known mental health conditions had a significantly higher likelihood of any relationship problem/loss (45.1%) than did those with known mental health conditions (39.6%), specifically intimate partner problems (30.2% versus 24.1%), arguments/conflicts (17.5% versus 13.6%), and perpetrating interpersonal violence in the past month (3.0% versus 1.4%). Decedents without known mental health conditions were also more likely than were those with known mental health conditions to have experienced any life stressors (50.5% versus 47.2%) such as recent criminal legal problems (10.7% versus 6.2%) or eviction/loss of home (4.3% versus 3.4%) and were more likely to have had a recent or impending (within the preceding or upcoming 2 weeks, respectively) crisis (a current or acute event thought to contribute to the suicide) (32.9% versus 26.0%). All of these differences remained significant in the adjusted models. Physical health problems and job/financial problems were commonly contributing stressors among both persons without mental health conditions (23.2% and 15.6%, respectively) and those with mental health conditions (21.4%

TABLE 1. (*Continued*) Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Toxicology results						
Any toxicology testing	**13,317 (65.1)**	6,658 (70.8)	6,659 (60.3)	<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	**9,913 (74.4)**	5,192 (78.0)	4,721 (70.9)	<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected* **						
Alcohol						
Tested	**10,950 (53.6)**	5,409 (57.5)	5,541 (50.2)	<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	**4,442 (40.6)**	2,115 (39.1)	2,327 (42.0)	<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	**8,554 (41.8)**	4,258 (45.3)	4,296 (38.9)	<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	**2,279 (26.6)**	1,238 (29.1)	1,041 (24.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	**8,124 (39.7)**	4,226 (44.9)	3,898 (35.3)	<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	**2,464 (30.3)**	1,639 (38.8)	825 (21.2)	<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	**7,978 (39.0)**	3,866 (41.1)	4,112 (37.2)	<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	**499 (6.3)**	216 (5.6)	283 (6.9)	<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	**7,615 (37.2)**	3,696 (39.3)	3,919 (35.5)	<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	**736 (9.7)**	376 (10.2)	360 (9.2)	NS	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	**6,569 (32.1)**	3,127 (33.2)	3,442 (31.2)	<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	**1,471 (22.4)**	710 (22.7)	761 (22.1)	NS	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	**5,425 (26.5)**	3,103 (33.0)	2,322 (21.0)	<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	**2,214 (40.8)**	1,735 (55.9)	479 (20.6)	<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviations: CI = confidence interval; NA = not adjusted; NS = not significant; OR = odds ratio.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology testing.

*** Denominator for each positive group is the number tested for the substance in that group.

and 16.8%, respectively). Similarly, among all persons with recent crises, intimate partner problems were the most common types and did not differ by group.

Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR = 0.5, 95% CI = 0.4–0.5). Among those recently released, decedents without known mental health conditions were significantly more likely than decedents with mental health conditions to have been released from a correctional facility (25.7% versus 8.7%), hospital (43.7% versus 33.0%), or other facility, such as an alcohol/substance use treatment facility (24.2% versus 11.6%). Among decedents with known mental health conditions who were recently released from an institution, 46.7% were released from psychiatric facilities.

Decedents without known mental health conditions were significantly less likely to have a history of suicidal ideation (23.0%) or prior suicide attempts (10.3%) compared with those with known mental health conditions (40.8% and 29.4%, respectively). Suicide intent was disclosed by 22.4% and 24.5% of persons without and with known mental health conditions, respectively.

Conclusions and Comments

During 1999–2016, suicide rates increased significantly in 44 states, and 25 states experienced increases >30%. Rates increased significantly among males in 34 states, and females in 43 states. Additional research into the specific causes of these trends is needed. Data from the 27 states participating in NVDRS provide important insight into circumstances surrounding suicide and can help states identify prevention priorities.

TABLE 2. Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	**18,764 (91.8)**	9,407 (100)	9,357 (84.8)	<0.01	N/A	N/A
Mental health						
Any current diagnosed mental health condition**						
Depression/Dysthymia	—††	7,076 (75.2)	N/A	N/A	N/A	N/A
Anxiety disorder	—††	1,579 (16.8)	N/A	N/A	N/A	N/A
Bipolar disorder	—††	1,431 (15.2)	N/A	N/A	N/A	N/A
Schizophrenia	—††	509 (5.4)	N/A	N/A	N/A	N/A
PTSD	—††	424 (4.5)	N/A	N/A	N/A	N/A
ADD/ADHD	—††	226 (2.4)	N/A	N/A	N/A	N/A
Not specified	—††	760 (8.1)	N/A	N/A	N/A	N/A
Current depressed mood§§	**7,038 (37.5)**	3,962 (42.1)	3,076 (32.9)	<0.01	0.7 (0.6–0.7)	0.7 (0.6–0.7)
Problematic substance use						
Any	**5,319 (28.3)**	2,976 (31.6)	2,343 (25.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Alcohol	**3,268 (17.4)**	1,862 (19.8)	1,406 (15.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Other	**3,084 (16.4)**	1,768 (18.8)	1,316 (14.1)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Treatment						
Current mental health/substance use treatment	**5,141 (27.4)**	5,077 (54.0)	64 (0.7)	<0.01	0.01 (0.01–0.01)	0.01 (0.01–0.01)
Ever treated for mental health/substance disorder	**6,717 (35.8)**	6,323 (67.2)	394 (4.2)	<0.01	0.02 (0.02–0.02)	0.02 (0.02–0.03)
Relationship problems/loss						
Any relationship problem/loss	**7,948 (42.4)**	3,726 (39.6)	4,222 (45.1)	<0.01	1.3 (1.2–1.3)	1.3 (1.2–1.4)
Intimate partner problem	**5,098 (27.2)**	2,270 (24.1)	2,828 (30.2)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Perpetrator of interpersonal violence in past month	**414 (2.2)**	131 (1.4)	283 (3.0)	<0.01	2.2 (1.8–2.7)	2.0 (1.6–2.4)
Victim of interpersonal violence in past month	**84 (0.4)**	53 (0.6)	31 (0.3)	<0.05	0.6 (0.4–0.9)	0.8 (0.5–1.2)
Family relationship problem	**1,671 (8.9)**	873 (9.3)	798 (8.5)	NS	0.9 (0.8–1.0)	1.0 (0.9–1.1)
Other relationship problem (nonintimate)	**403 (2.1)**	202 (2.1)	201 (2.1)	NS	1.0 (0.8–1.2)	1.1 (0.9–1.3)
Argument or conflict (not specified)	**2,914 (15.5)**	1,278 (13.6)	1,636 (17.5)	<0.01	1.3 (1.2–1.5)	1.4 (1.3–1.5)
Death of a loved one (any)	**1,497 (8.0)**	826 (8.8)	671 (7.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–0.9)
Nonsuicide death	**1,181 (6.3)**	647 (6.9)	534 (5.7)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Suicide of family or friend	**379 (2.0)**	217 (2.3)	162 (1.7)	<0.01	0.7 (0.6–0.9)	0.8 (0.7–1.0)
Other life stressors						
Any life stressor	**9,171 (48.9)**	4,442 (47.2)	4,729 (50.5)	<0.01	1.1 (1.1–1.2)	1.1 (1.0–1.2)
Recent criminal legal problem	**1,588 (8.5)**	586 (6.2)	1,002 (10.7)	<0.01	1.8 (1.6–2.0)	1.7 (1.5–1.9)
Other legal problem	**748 (4.0)**	378 (4.0)	370 (4.0)	NS	1.0 (0.8–1.1)	1.0 (0.9–1.2)
Physical health problem	**4,179 (22.3)**	2,012 (21.4)	2,167 (23.2)	<0.01	1.1 (1.0–1.2)	1.0 (1.0–1.1)
Job/Financial problem¶¶	**2,941 (16.2)**	1,530 (16.8)	1,411 (15.6)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Eviction or loss of home	**722 (3.8)**	317 (3.4)	405 (4.3)	<0.01	1.3 (1.1–1.5)	1.4 (1.2–1.6)
School problem***	**162 (19.9)**	70 (17.8)	92 (21.9)	NS	1.3 (0.9–1.8)	1.3 (0.9–1.9)
Recent release from an institution†††	**1,412 (7.6)**	941 (10.2)	471 (5.1)	<0.01	0.5 (0.4–0.5)	0.5 (0.4–0.5)
Jail/Prison/Detention facility	**203 (14.4)**	82 (8.7)	121 (25.7)	<0.01	3.6 (2.7–4.9)	4.5 (3.2–6.4)
Hospital	**517 (36.6)**	311 (33.0)	206 (43.7)	<0.01	1.6 (1.3–2.0)	1.3 (1.0–1.7)
Psychiatric hospital/institution	**469 (33.2)**	439 (46.7)	30 (6.4)	<0.01	0.1 (0.1–0.1)	0.1 (0.1–0.1)
Other (includes alcohol/SU treatment facilities)	**223 (15.8)**	109 (11.6)	114 (24.2)	<0.01	2.4 (1.8–3.3)	2.5 (1.8–3.3)

See table footnotes on next page.

Suicidologists regularly state that suicide is not caused by a single factor (*5*); however, suicide prevention is often oriented toward mental health conditions alone with regard to downstream identification of suicidal persons, treatment of mental health conditions, and prevention of reattempts. This study found that approximately half of suicide decedents in NVDRS did not have a known mental health condition, indicating that additional focus on nonmental health factors further upstream could provide important information for a public health approach (*10*). Those without a known mental health condition suffered more from relationship problems and other life stressors such as criminal/legal matters, eviction/loss of home, and recent or impending crises.

Similarly, persons with mental health conditions also often experienced other circumstances such as relationship problems and job/financial or physical health problems that contributed to their suicide. These findings point to the need to both prevent the circumstances associated with the onset of mental health conditions and support persons with known mental health conditions to decrease their risk for poor outcomes (*11*). Two thirds of suicide decedents with mental health conditions had a history of treatment for mental health or substance use disorders,

TABLE 2. (*Continued*) Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Crisis within past or upcoming 2 weeks§§§	**5,525 (29.4)**	2,444 (26.0)	3,081 (32.9)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Intimate partner problem	**1,968 (35.6)**	854 (34.9)	1,114 (36.2)	NS	1.1 (0.9–1.2)	1.1 (0.9–1.2)
Physical health problem	**739 (13.4)**	315 (12.9)	424 (13.8)	NS	1.1 (0.9–1.3)	1.0 (0.8–1.2)
Criminal legal problem	**621 (11.2)**	203 (8.3)	418 (13.6)	<0.01	1.7 (1.5–2.1)	1.6 (1.3–1.9)
Family relationship problem	**430 (7.8)**	212 (8.7)	218 (7.1)	<0.05	0.8 (0.7–1.0)	0.9 (0.7–1.1)
Job problem	**354 (6.4)**	191 (7.8)	163 (5.3)	<0.01	0.7 (0.5–0.8)	0.7 (0.5–0.8)
Suicide event/history						
Left a note	**6,468 (34.5)**	3,182 (33.8)	3,286 (35.1)	NS	1.1 (1.0–1.1)	1.2 (1.1–1.2)
Disclosed suicide intent	**4,405 (23.5)**	2,306 (24.5)	2,099 (22.4)	<0.01	0.9 (0.8–1.0)	0.9 (0.8–0.9)
History of ideation	**5,990 (31.9)**	3,838 (40.8)	2,152 (23.0)	<0.01	0.4 (0.4–0.5)	0.4 (0.4–0.5)
History of attempts	**3,732 (19.9)**	2,770 (29.4)	962 (10.3)	<0.01	0.3 (0.3–0.3)	0.3 (0.3–0.3)

Abbreviations: ADD/ADHD = attention deficit disorder/attention deficit hyperactivity disorder; CI = confidence interval; N/A = not applicable; NS = not significant; OR = odds ratio; PTSD = posttraumatic stress disorder; SU = substance use.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was the reference group.

** Includes decedents with one or more diagnosed current mental health conditions, which are not mutually exclusive. Therefore, sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health conditions.

†† The specific type of mental health condition was calculated only among those with one or more known diagnosed mental health conditions.

§§ Not a diagnosis.

¶¶ Denominator is decedents aged ≥18 years.

*** Denominator is decedents aged 10–18 years.

††† Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.

§§§ Denominator of crisis subgroup is decedents with any crisis within past or upcoming 2 weeks. Crises depicted here represent the most commonly occurring categories.

with approximately half in treatment when they died. This finding suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities, such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. In addition, increased access to behavioral health providers in underserved areas is needed, as is expansion of health care systems that integrate physical and behavioral health, with a priority on suicide prevention and patient safety, especially through care transitions (*12*).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belonging and access to informational, tangible, emotional, and social support; and identifying and better supporting persons at risk (e.g., military veterans, persons with physical/mental health conditions) (*12*). Other strategies include creating protective environments (e.g., reducing access to lethal means among persons at risk for suicide, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for persons with mental health conditions and other life challenges), strengthening access to and delivery of care, supporting family and friends after a suicide, and encouraging the media to follow safe reporting recommendations (*12*). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (*10*).

The findings in this report are subject to at least three limitations. First, in the state-level analysis, rankings for four states (Maryland, Massachusetts, Rhode Island, and Utah) might have been affected by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward) or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml). Finally, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies that include more in-depth interviews with next-of-kin often identify greater attributions to mental health disorders

Summary

What is already known about this topic?

In 2016, nearly 45,000 persons died by suicide in the United States. Mental health conditions are one of several contributors to suicide.

What is added by this report?

During 1999–2016, suicide rates increased in nearly every state, including >30% increases in 25 states. 2015 data from 27 states indicate 54% of suicide decedents were not known to have mental health conditions. Relationship, substance use, health, and job or financial problems are among the other circumstances contributing to suicide.

What are the implications for public health practice?

A comprehensive approach using proven prevention strategies, such as those in CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, can help reach the national goal of reducing the annual suicide rate 20% by 2025.

(*13*); however, many methodological variations across studies exist (*14*). It is likely that some persons without known mental health conditions in the current study were experiencing mental health challenges that were unknown, undiagnosed, or not reported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (*12*) to better understand suicide in their populations, prioritize evidence-based comprehensive suicide prevention, and save lives.

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Conflict of Interest

No conflicts of interest were reported.

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Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

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State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30 ¶¶)	+ 34.1 % (23 ¶¶)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3 ¶¶)	+ 46.5 % (4 ¶¶)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Different ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Different ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Different ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

State Abbreviations: AL Alabama; AK Alaska; AZ Arizona; AR Arkansas; CA California; CO Colorado; CT Connecticut; DE Delaware; DC District of Columbia; FL Florida; GA Georgia; HI Hawaii; ID Idaho; IL Illinois; IN Indiana; IA Iowa; KS Kansas; KY Kentucky; LA Louisiana; ME Maine; MD Maryland; MA Massachusetts; MI Michigan; MN Minnesota; MS Mississippi; MO Missouri; MT Montana; NE Nebraska; NV Nevada; NH New Hampshire; NJ New Jersey; NM New Mexico; NY New York; NC North Carolina; ND North Dakota; OH Ohio; OK Oklahoma; OR Oregon; PA Pennsylvania; RI Rhode Island; SC South Carolina; SD South Dakota; TN Tennessee; TX Texas; UT Utah; VT Vermont; VA Virginia; WA Washington; WV West Virginia; WI Wisconsin; WY Wyoming.

#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



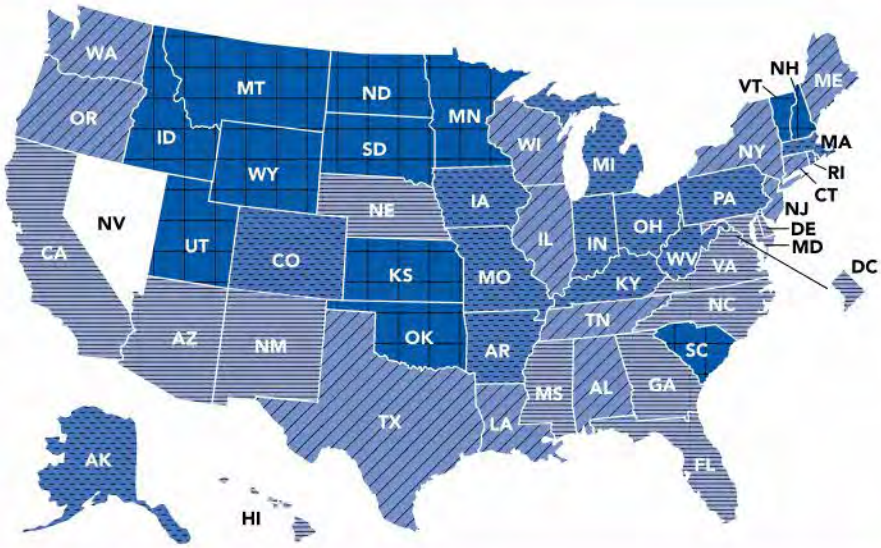
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

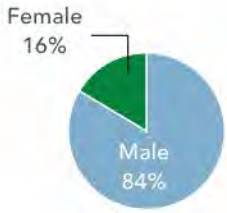


Differences exist among those with and without mental health conditions.

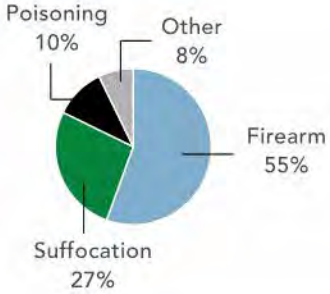
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

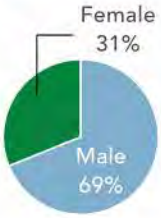


Method

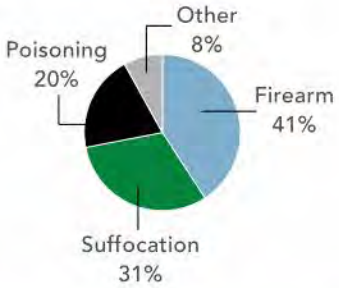


Known mental health conditions

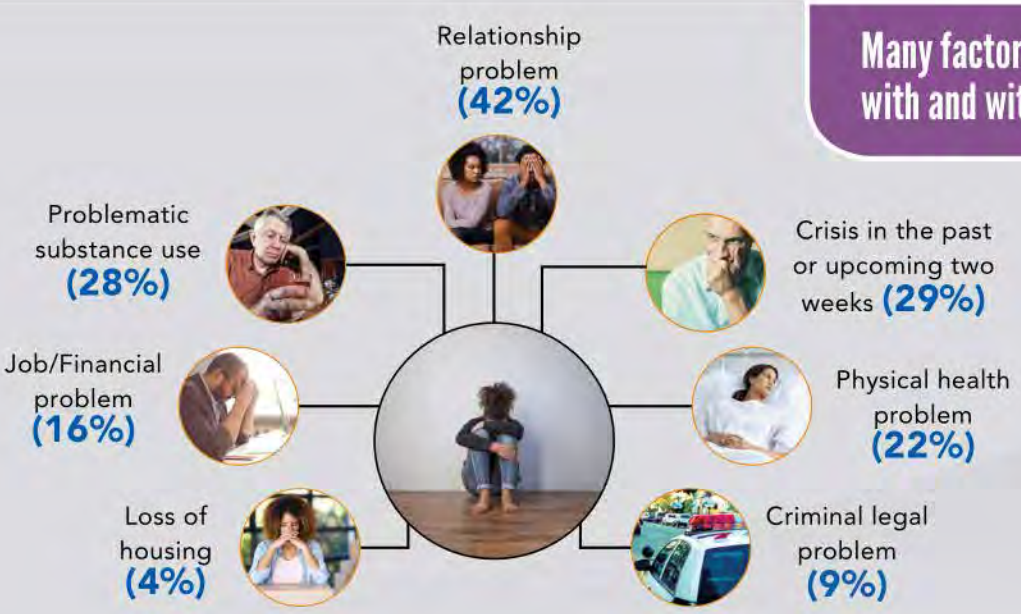
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018

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Review Tracker

- NCIPC OC Leslie Dorigo: 4/25/18
- DVP ADS Tom Simon: 4/24/18
- DVP Policy Malia Richmond-Crum: 4/23/18
- DVP SME Deb Stone: 4/19/18, 4/24/18, 5/13 5/17
- DVP HCET Marie Ballman: 4/17/2018
- LS-OADC: 5/1/2018
- KSG-OADC: 5/4/2018

Suicide Terminology	
Don't Do This	**Do This Instead**
Don't use sensationalistic headlines (e.g., Kurt Cobain used shotgun to commit suicide)	Do inform without sensationalizing (e.g. Curt Cobain dead at 27)
Don't describe suicide as an epidemic, skyrocketing, etc.	Do use the most recent CDC data and non-sensational words (rise, higher, etc.)
Don't describe suicide as inexplicable or "without warning"	Do include the 'warning signs' and 'what to do' info in articles
Don't refer to suicides or attempts as 'successful' or 'completed'	Describe as suicide, person died by suicide, or life lost to suicide
Don't refer to suicide attempts as 'unsuccessful,' 'failed attempt' or 'nonfatal suicide'	Describe as 'suicide attempt' or 'suicidal self-directed violence'
Don't use 'committed' suicide because this invokes the idea of a crime	Describe as died by suicide

Vital Signs Rising Suicide Rates Across U.S.

June 7, 2018

Desired Headlines

- Nearly 45,000 lives lost to suicide in 2016, but suicide is preventable.
- Suicide rates up in almost all states, but suicide is preventable.
- Suicide rates went up more than 30% in half of U.S. states between 1999 and 2016.
- Many factors contribute to suicide, beyond mental health conditions alone.

Moderator: Thank you (OPERATOR NAME). And thank you all for joining us today for the release of a new CDC Vital Signs report on Trends in State Suicide Rates and contributing circumstances to suicide. We are joined by Dr. Anne Schuchat, CDC's Principal Deputy Director and the Surgeon General Dr. Jerome Adams. Dr. Deb Stone,

lead author of the study, is also available to help answer questions. Following remarks, we will respond to questions. I'd like to turn the call over now to Dr. Anne Schuchat.

Dr. Schuchat:

- Good afternoon and thank you for joining us today.
- CDC works 24/7 to protect Americans against health threats. Each month in CDC's *Vital Signs* report, **we focus on one of these threats – and what can be done about it**.
- Today's report contains **new information about state suicide trends, and the range of factors that contribute to suicide.**
- In 2016 alone, **45,000 people in the U.S. lost their lives to suicide.**
- **Between 1999 and 2016, s~~S~~uicide rates have increased among all age groups** younger than 75 years, with the ~~highest~~largest percent increase *and* the most suicides occurring among those aged 45-64. ~~and those aged 10-14.~~
- We found that **suicide rates have increased in nearly every state** across the nation – and suicide is one of just three leading causes of death that are on the rise.

- Suicide greatly impacts families, friends, colleagues, and entire communities. **These findings are unacceptable.**
- **Suicide is a preventable public health problem –** and unfortunately, our data show that the problem is getting worse.
- For this *Vital Signs* report, we first analyzed data from the National Vital Statistics System to look at trends in suicide rates for all 50 states and Washington, D.C.
- We then looked at data from CDC's National Violent Death Reporting System, covering 27 states in 2015, and examined circumstances around suicides among people with and without known mental health conditions. As a side note, in the coming year CDC will have data for 40 states, D.C. and Puerto Rico, and thanks to Congress for providing funding in the fiscal year 2018 omnibus, CDC is working to expand the system to all 50 states.
- **Suicide is often attributed solely to a mental health condition. But according to NVDRS, fewer than half of the people who lost their life to suicide had a known mental health condition – and in many of these cases, other factors were involved.**
- In fact, our research found that people who died by suicide and *did not* have a diagnosed mental health condition were somewhat more likely than those *with* a mental health condition to struggle with **relationship problems or loss, life**

stressors and **recent or impending crises**. However, and **importantly**, these circumstances were common to both groups.

- **Suicide IS preventable.**
- That's why it's so important to know the full range of factors that contribute to suicide risk including relationship problems, substance use, physical and mental health conditions, job issues, financial trouble, and criminal and/or legal problems.
- With this information in mind, states and communities can develop a comprehensive approach to suicide prevention. For example, The United States Air Force Suicide Prevention Program, inclusive of 11 policy and education initiatives geared broadly towards increasing social support, social skills, and help-seeking, shifted the culture of the Air Force away from viewing suicide as an individual-oriented mental health condition to a larger service-wide problem impacting the whole community. The program was associated with a 33% relative risk reduction in suicide and reductions in other related problems.
- Increased awareness of the range of circumstances contributing to suicide risk, and the needed to address them, can help the nation reach its goal of reducing the annual suicide rate 20 percent by 2025.

- Today's report suggests we have a lot of important work to do to reach this goal. Nearly **all states had increasing suicide rates between 1999 and 2016, and 25 states experienced rate increases of more than 30 percent.**
- So how do we work together to reverse these numbers and help save lives?
- Close coordination of activities between public health agencies and other sectors of society is critical for preventing suicide. Necessary partners include such sectors as health and mental healthcare providers; social services; first responders; educators; faith communities; employers; and the media.
- States and communities **can and should take action now** based on the best available evidence.
- To help prioritize prevention efforts, we've developed *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* It features the best available evidence for states and communities to guide their prevention priorities. The link to the technical package is on our *Vital Signs* website.
- **Preventing suicide involves everyone. Parents, employers, teachers, coaches, religious leaders – everyone in the community** can help prevent suicide risk, learn the warning signs of suicide, and how best to respond and get help.
- Now I'm going to turn it over to Dr. Adams for more discussion about suicide.

Dr. Adams:

- Thank you, Rear Admiral Anne Schuchat. As the nation's doctor, I am grateful for CDC's important study and work ~~i~~on suicide prevention. ~~this public health crisis.~~
- As Dr. Schuchat noted, suicide is a devastating national problem. It's simply not acceptable that we are losing nearly 45,000 lives a year to suicide, a preventable public health problem. ~~in this country, many of whom are military members or veterans.~~
- Almost all of us have been affected by, or know someone ~~affected by~~who died by, suicide, be they military members, veterans, friends, co-workers, or family, and yet the topics of suicide and help seeking remain~~s~~ incredibly stigmatized.
- I firmly believe that in order to address the tragedy that is taking one's own life; we need to take a hard look at the underlying factors that can lead to suicide, as RADM Schuchat stated.
- Although mental health ~~problems~~ conditions are ~~perhaps~~ one of the most discussed causes of suicide, we must also take into account upstream, or earlier, contributors to suicide~~auses~~. These include relationship problems or loss, substance use, job, financial, and health problems.
- Even earlier in life, factors such as adverse childhood experiences, or ACEs, contribute to suicide risk ~~which~~and can trigger suicide attempts and mental health ~~problems~~ conditions in the future.
- As I travel across the country, I have heard heart-breaking stories about ~~the relationship between trauma and suicide~~suicide and suicide attempts.
- Recently, a friend of mine shared her own connection with suicide. She experienced a traumatic event growing up and while trying to come to terms with the pain and betrayal she experienced since the event, she attempted to take her

Comment [zaf9]: Moved this down in order to highlight and broaden to include the many people we lose every day who are and are not military members or veterans.

Comment [zaf9]: We've been asked to change our term mental health problems to mental health conditions.

Comment [zaf9]: Suggest adding this to be in line with the study. Moved ACES down.

Comment [zaf9]: This is a good addition but suggest keeping this a little broader since we don't get into trauma in our study. The spirit of this is still retained.

Comment [zaf9]: Is this correct to add? Wanted to tie this back to ACEs as I believe is the intent.

Comment [zaf9]: Is this correct to add?

own life. Thankfully, ~~she was saved by~~ her parents responded quickly and effectively and she received the ~~who rushed her to receive~~ medical attention, ~~-~~ care and support she needed that saved her life. ~~-~~Today she is doing well and continues on her healing journey.

- This story of suicide risk is all too common, and too frequently, people are not as lucky as my friend who got the help she needed. ~~has a much more grim outcome, which~~This is why we ~~are~~must take~~ing important~~further action to ~~strides to~~ address ~~the suicide crisis~~rising suicide rates and the full range of contributing factors.
- On the Federal level, government agencies are tracking the problem of suicide to understand trends and groups at greatest risk. We are developing, implementing, and evaluating what works to prevent suicide in communities. And we are working with public and private partners to advance the National Strategy for Suicide Prevention.
- ~~The good news is that there are opportunities for prevention.~~ This *Vital Signs* report reminds us that health care systems, inclusive of physical and behavioral health care ~~and~~ providers, have an important role~~s~~ to play in preventing the risk of suicide so that nobody falls through the cracks. Well-trained ~~Some specific things healthcare~~ providers and healthcare systems can: ~~do:~~
  - ~~First, you can help make sure there are systems~~ Put into place policies and protocols ~~in place~~ that prioritize patient safety including screening and assessing for suicide risk, per clinical guidelines. ~~and train staff in suicide care, practices, and protocols, including safety planning.~~
  - Can
  - engage and support people in ongoing care using evidence-based treatments for suicide prevention, and

Comment [zaf9]: Suggest broadening what she received here.

Comment [zaf9]: Suggest adding this, as a field we are trying to also highlight that a lot of people who attempt don't go on to die by suicide but live fulfilling lives.

Comment [zaf9]: Suggest striking this because the paragraph above is also about prevention so these would be in addition to those things.

Comment [zaf9]: The remaining comments are in reference to a program called "Zero Suicide" (in our technical package and is a priority of the National Action Alliance for Suicide Prevention) which is based on an evidence based program out of Henry Ford hospital "Perfect depression care"

- can tSecond, you can talk with people who are at risk and their families about how to store lethal means such as medications and firearms.
- Third, you can screen your patients for signs of ACEs or other underlying traumas that could place them at higher risk for suicidal ideation and/or attempts.
- Finally, it is important to integrate and coordinate physical and behavioral/mental health care in ways that keep patients safe and engaged in care.

Comment [zaf9]: Theses comments have been integrated above now.

- Today's report shows that there are many factors that contribute to suicide risk. Everyone has a responsibility to help stop this alarming concerning trend.
- **Thank you, I'll turn it back to Dr. Schuchat now.**

- **Thank you for your comments, Dr. Adams.**

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: 15 Feb 2018 08:21:28 -0500
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Sokler, Lynn (CDC/OD/OADC);Peaker, Brandy (CDC/OPHSS/CSELS/DPHID);Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Subject: FW: Clarification of meeting dates and details

Hi Deb,
Please see below. The podcast is not on the calendar because it's now optional. Most programs have opted to have one. It typically only takes an hour or less to review the script and the recording can be attended by conference call. Would you like to have a podcast for the June VS?
Shannon

Shannon Omisore, MA
Health Communication Specialist
Office of the Associate Director for Communication
2500 Century Parkway, MS E-21
Atlanta, GA 30345
Office: 404-498-0153
E-mail: hyl5@cdc.gov

CDC 24/7 Saving Lives. Protecting People.™

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, February 12, 2018 12:49 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: Clarification of meeting dates and details

Hi Lynn,
It was nice to meet you last week at the kick-off meeting. I was reviewing the calendar and the list of meetings (from the CDC Vital Signs Products document) side by side and I had some questions. Would you be able to check the info I have and fill in any of the blanks? I just want to make sure everything gets on the calendar accurately and with plenty of notice. Also, if you could let me know what the colors on the calendar mean again that would be helpful. I know the green are items with the same date and it looks like pink indicates program deliverables (but not all). Thank you!
Deb

Meeting	Date	Time	Location	Corresponding step from calendar	Note
~~1. Initial Kick-off~~	**~~February 8, 2018~~**	**~~9-10:30~~**	**~~Chamblee~~**	~~_____~~	**completed**
2. Roundtable	**April 3**	**1:30-4:30**	**Chamblee**	**13**	
3. Social Media kickoff prep call	**April 24 (This is the deadline for the**			**35**	

	call; the actual call will be scheduled closer to that date. Becky McDaniel [ldy8] is the POC.)				
4. Recording of podcast (by phone or in person)	May 29 (Charlotte Duggan [ctd3], the POC, will schedule the time closer to that date.)				Don't see this on calendar
5. NPHIC Call	May 31			42	
6. Pre-briefing meetings with Director/AS	This has not been scheduled yet.		Bldg 21, 12th fl	41	
7. Media Telebriefing and pre-release meeting	June 5	11:40	Bldg 21, 12th fl	48	
8. OSTLTS Town Hall	June 12 (Tonya Joyner [wyl6] is the POC.)			51	

Deb Stone, ScD, MSW, MPH
Behavioral Scientist
Suicide, Youth Violence, and Elder Maltreatment Team
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
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4770 Buford Highway, MS F-64
Atlanta, GA 30341
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dstone3@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 8 Jun 2018 14:32:09 +0000
To: Yuan, Keming (CDC/ONDIEH/NCIPC);Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Subject: FW: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Can either of you help answer this questions?
Think it's things like Benadryl etc but not sure if there's a specific list or descriptor.
Deb

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 10:15 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: FW: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

See question below re the VS.

From: Colleen Creighton <ccreighton@suicidology.org>
Sent: Thursday, June 7, 2018 5:45 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin – Thanks so much for the call today and for all your work going into this report. One question that came up from our end is under "Other" – what is included in this category in addition to OTCS?

Other (e.g., over-the-counter)	**1,021 (34.0**

Thanks so much,

Colleen

Colleen Creighton
Executive Director
American Association of Suicidology
5221 Wisconsin Avenue, NW, 2nd Floor
Washington, DC 20015
T: (202) 237-2280, F: (202) 237-2282
Direct: 202-830-3399
Register for FREE trainings here:
www.USMilitaryMatters.org
www.suicidology.org



AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide.

AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 10:04 AM
To: Torguson, Kimberly <KTorguson@edc.org>; Belyeu, Avery <ABelyeu@edc.org>; jbenson@reingold.com; Bray, Miranda (SAMHSA/OC) <Miranda.Bray@samhsa.hhs.gov>; Sam.Brinton@thetrevorproject.org; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Carr, Colleen <ccarr@edc.org>; SCoggin@afsp.org; Colleen Creighton <ccreighton@suicidology.org>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Curtin, Sally C. (CDC/OPHSS/NCHS) <sac2@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Ashby.Dodge@thetrevorproject.org; mgdyak@eiconline.org; johnd@mhaofnyc.org; fgonzalez@mhaofnyc.org; Gass, Jesse <JGass@edc.org>; Hausman, Bridgette <BHausman@edc.org>; Hedegaard, Holly (CDC/OPHSS/NCHS) <hdh6@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Amy Kulp <ajkulp@suicidology.org>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; wendy.e.lakso.civ@mail.mil; plauricella@reingold.com; sheri.lunn@thetrevorproject.org; Chris Maxwell <cmaxwell@suicidology.org>; McElroy, James (NIH/NIMH) [E] <james.mcelroy@nih.gov>; McShane, Kristen (SAMHSA/OC) <Kristen.Mcshane@samhsa.hhs.gov>; steve.mendelsohn@thetrevorproject.org; eneely@reingold.com; AOBrien@afsp.org; O'Keefe, Lindsey (NIH/NIMH) [E] ; Amit.Paley@thetrevorproject.org; jpearson@nih.gov; Pearson, Jane L (NIH/NIMH) [E] <jpearson@mail.nih.gov>; Reed, Jerry <jreed@edc.org>; dreidenberg@save.org; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; mrosen@mhaofnyc.org; michaelle.scanlon@nih.gov; Sobottka, Linda <lsobottka@edc.org>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Stout, Elly <estout@edc.org>; calvin.stowell@thetrevorproject.org; AVactor@mhaofnyc.org; Warner, Margaret (CDC/OPHSS/NCHS) <mmw9@cdc.gov>; katherine.v.warrick.civ@mail.mil; kevin.wong@thetrevorproject.org; Wright, James (SAMHSA/DPTSSP) <James.Wright@samhsa.hhs.gov>
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

In prep for our call today to discuss our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* attached is an **embargoed** copy of the Fact Sheet. The Vital Signs includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions. We appreciate this partnership and hope you can all help us disseminate the Vital Signs to your networks once the **embargo lifts at 1:00 pm**.

Erin

****

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains an advance copy of the four-page *Vital Signs* fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; the attachment is EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

-----Original Appointment-----

From: Torguson, Kimberly <KTorguson@edc.org>

Sent: Monday, May 14, 2018 6:59 PM

To: Torguson, Kimberly; Belyeu, Avery; jbenson@reingold.com; Black, Erin (CDC/ONDIEH/NCIPC); Bray, Miranda (SAMHSA/OC); Sam.Brinton@thetrevorproject.org; Bruce, Crystal (CDC/OPHPR/OD); Carr, Colleen; SCoggin@afsp.org; ccreighton@suicidology.org; Crosby, Alexander (CDC/ONDIEH/NCIPC); Curtin, Sally C. (CDC/OPHSS/NCHS); Daniel, Valerie M. (CDC/ONDIEH/NCIPC); Ashby.Dodge@thetrevorproject.org; mgdyak@eiconline.org; JohnD@mhaofnyc.org; fgonzalez@mhaofnyc.org; Gass, Jesse; Hausman, Bridgette; Hedegaard, Holly (CDC/OPHSS/NCHS); Holland, Kristin (CDC/ONDIEH/NCIPC); ajkulp@suicidology.org; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC); wendy.e.lakso.civ@mail.mil; plauricella@reingold.com; sheri.lunn@thetrevorproject.org; cmaxwell@suicidology.org; McElroy, James (NIH/NIMH) [E]; McShane, Kristen (SAMHSA/OC); steve.mendelsohn@thetrevorproject.org; eneely@reingold.com; AOBrien@afsp.org; O'Keefe, Lindsey (NIH/NIMH) [E]; Amit.Paley@thetrevorproject.org; jpearson@nih.gov; Pearson, Jane L (NIH/NIMH) [E]; Reed, Jerry; dreidenberg@save.org; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); mrosen@mhaofnyc.org; michaelle.scanlon@nih.gov; Sobottka, Linda; Stone, Deborah (CDC/ONDIEH/NCIPC); Stout, Elly; calvin.stowell@thetrevorproject.org; AVactor@mhaofnyc.org; Warner, Margaret (CDC/OPHSS/NCHS); katherine.v.warrick.civ@mail.mil; kevin.wong@thetrevorproject.org; Wright, James (SAMHSA/DPTSSP)

Subject: Media Messaging Work Group Call

When: Thursday, June 7, 2018 11:00 AM-11:30 AM (UTC-05:00) Eastern Time (US & Canada).

Where: Phone Number: 866-370-2808 (access code (b)(6

Phone Number: 866-370-2808 (access code (b)(6

Email Context (From 5/14):

Hello Media Messaging Work Group (MMWG),

Following the email below, we wanted to let you know that the CDC data expected to be released on June 5 will **now be released on June 7**. Additionally, we received word that we will not be receiving an embargoed copy so we'll be rescheduling our MMWG group call (originally scheduled for Thursday, May 31) to **Thursday, June 7 at 11:00 a.m.**

The goal of this call is to convene our partners to: 1) discuss the data, and 2) develop consensus on our

messaging that will be used to craft a statement. If you are unable to join the call, you will still have the opportunity to weigh in on the statement via email.
We hope you can join us on Thursday, June 7 at 11:00 a.m.
Lastly, we want to thank CDC for giving us the heads up about the data.
Best,

Hello Media Messaging Work Group,
We wanted to call to your attention to a just-released article published in the *American Journal of Preventive Medicine* that looks at county-specific estimates of suicide rates. The paper titled "County-level Trends in Suicide Rates in the U.S., 2005-2015" was written by our Partner, CDC (authors include: Lauren M. Rossen, Holly Hedegaard, Diba Khan and Margaret Warner from NCHS).
Key findings include:

- Posterior predicted mean county-level suicide rates increased by >10% from 2005 to 2015 for 99% of counties in the U.S., with 87% of counties showing increases of >20%.
- Counties with the highest model-based suicide rates were consistently located across the western and northwestern U.S., with the exception of southern California and parts of Washington.
- Compared with more urban counties, more rural counties had the highest estimated suicide rates from 2005 to 2015, and also the largest increases over time.

Overall the data underscores the importance of looking at geographic areas to identify high risk and need for more coordinated and comprehensive community-based suicide prevention efforts in the U.S. While the Action Alliance does notplan to put out a formal statement about the data at this time, we encourage you to reference our past collective statement (written in collaboration with the MMWG partners) released last year that looks at suicide rates in urban and rural areas. You'll notice much of the information is very relevant and timely as it relates to the county-level trends data.
Please find below some tailorable social media posts to help further promote the data:

- Data released by @CDCInjury featured in @AmJPrevMed shows county-level trends in suicide rates in the US http://bit.ly/2IHo6hk
- New article featured in @AmJPrevMed underscores need for coordinated and comprehensive community-based suicide prevention efforts http://bit.ly/2IHo6hk
- Trends about suicide, like geographic patterns, helps us develop more targeted community-based #suicideprevention strategies http://bit.ly/2IHo6hk so we can reduce annual suicide rate 20% by 2025
- Rural counties in the U.S. had the highest estimated suicide rates from 2005-2015 according to just-released @AmJPrevMed http://bit.ly/2IHo6hk
- Tracking county-level suicide rates helps our field to better understand changes in suicide rates over time and develop more targeted suicide prevention efforts http://bit.ly/2IHo6hk
- Together we can reduce the annual suicide rate 20 percent by 2025 but we need continued research on community-level risk and protective factors as shown in recent data by @CDCinjury http://bit.ly/2IHo6hk

When posting, please consider incorporating Media Messaging Work Group Partner Twitter handles:

- @Action_Alliance
- @AASuicidology
- @afspnational
- @CDCInjury
- @CDCMMWR
- @DeptofDefense
- @DeptVetAffairs

- @EDCTweets
- @NIH
- @NIMHgov
- @ReingoldInc
- @samhsagov
- @SAVEvoicesofedu
- @SPRCtweets
- @TrevorProject
- @800273TALK

Some resources that you may also find helpful as you promote the data include:

- **Action Alliance's *Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention*** – A resource that outlines strategic components that should guide program planning and implementation at the community level.
- **CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*** – A resourcethat helps states and communities prioritize efforts to prevent suicide.

We wanted to give you all the heads up that CDC is also expected to release additional relevant data to inform suicide prevention efforts on or around June 5th. The Action Alliance Secretariat does plan to convene this group to develop consensus messaging around this impending data release. In preparation for this larger data release, we'll be convening the MMWG for a call in late May to discuss the data and our collective statement.

REQUEST: Please join us for a planning call on Thursday, May 31 at 2:00 p.m. ET to plan ahead for collective statement about CDC data.

We will send you a calendar invite (containing call-in information) to you shortly. If you are unable to participate on this call, you'll have the opportunity to weigh in on the statement electronically.

Lastly, we wanted to thank CDC for giving us the heads up about the data.

Thank you.

From: Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 09:37:24 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: FW: Embargoed until 1pm June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
Attachments: FACT SHEET_Vital Signs_June_2018_Suicide_Final_WEB.pdf, MMWR_Vital Signs_ Suicide_6.7.2018_article.pdf, MMWR Supplemental table__VS Suicide_ 6.7.2018_final.pdf

Congratulations!! Good luck today! I know you'll rock it!
S

From: Core VIPP (CDC)
Sent: Thursday, June 7, 2018 9:12 AM
Subject: Embargoed until 1pm June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Dear Colleague:

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

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- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
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Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Thank you for your support.

Debra Houry, MD, MPH
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#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

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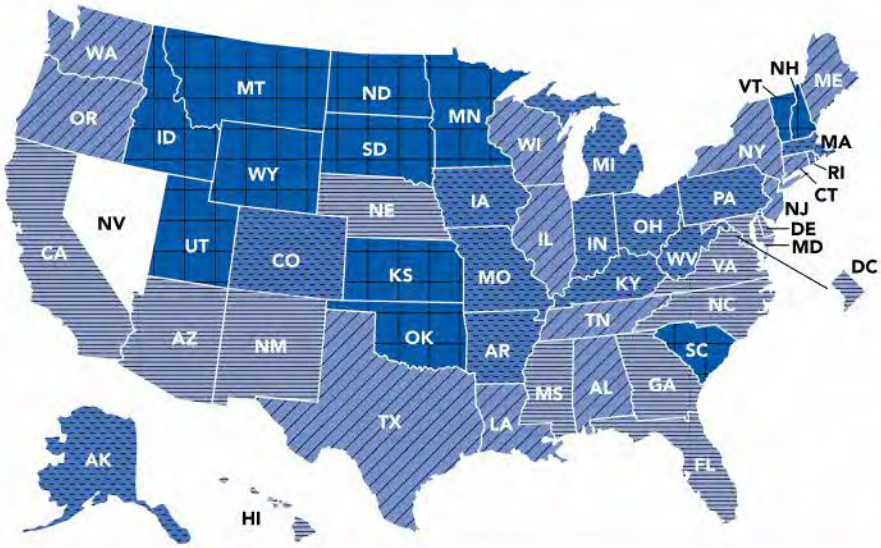
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

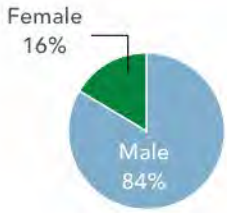


Differences exist among those with and without mental health conditions.

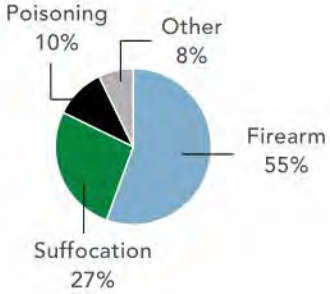
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

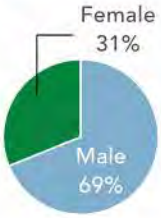


Method

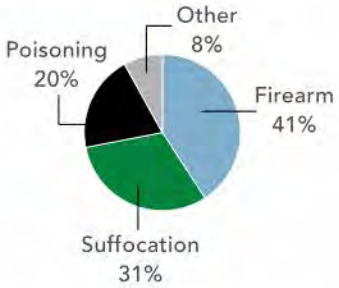


Known mental health conditions

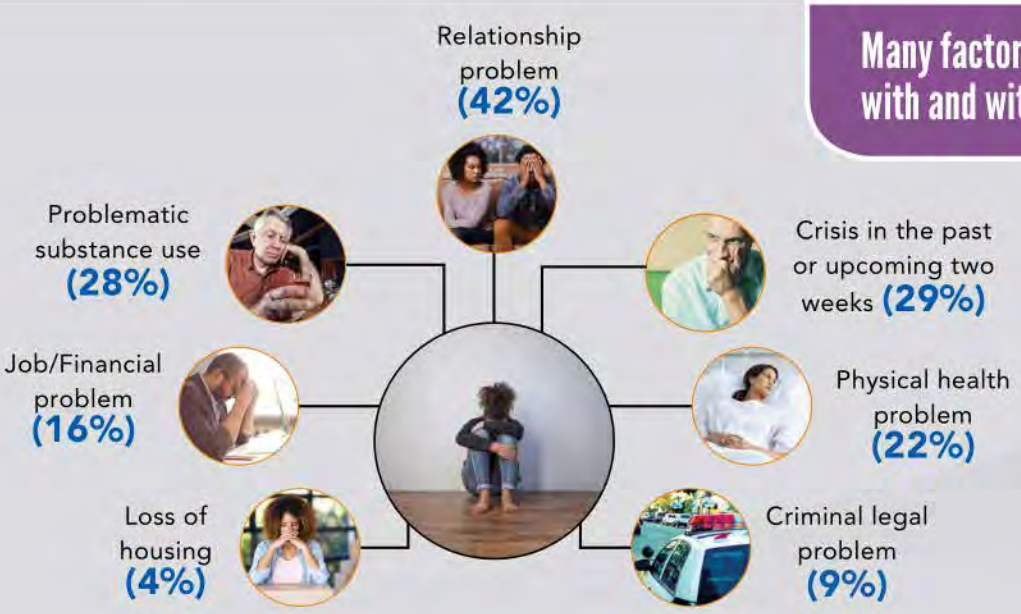
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
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Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

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Abstract

Introduction: Suicide rates in the United States have risen nearly 30% since 1999, and mental health conditions are one of several factors contributing to suicide. Examining state-level trends in suicide and the multiple circumstances contributing to it can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among persons aged ≥10 years, by state and sex, across six consecutive 3-year periods (1999–2016), were assessed using data from the National Vital Statistics System for 50 states and the District of Columbia. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health conditions.

Results: During 1999–2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases >30%. Rates increased significantly among males and females in 34 and 43 states, respectively. Fifty-four percent of decedents in 27 states in 2015 did not have a known mental health condition. Among decedents with available information, several circumstances were significantly more likely among those without known mental health conditions than among those with mental health conditions, including relationship problems/loss (45.1% versus 39.6%), life stressors (50.5% versus 47.2%), and recent/impending crises (32.9% versus 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states during 1999–2016. Various circumstances contributed to suicides among persons with and without known mental health conditions.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends and family members in the aftermath of a suicide.

INSIDE

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Centers for Disease Control and Prevention

Introduction

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (*1*). From 1999 to 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (*2,3*). Suicide rates have also increased among persons in all age groups <75 years, with adults aged 45–64 having the largest absolute rate increase (from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (232,108) during the same period (*1,3*). Suicide is the tenth leading cause of death and is one of just three leading causes that are increasing (*1,4*). In addition, rates of emergency department visits for nonfatal self-harm, a main risk factor for suicide, increased 42% from 2001 to 2016 (*1*). Together, suicides and self-harm injuries cost the nation approximately $70 billion per year in direct medical and work loss costs (*1*).

The National Strategy for Suicide Prevention (*5*) calls for a public health approach to suicide prevention with efforts spanning multiple levels (individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is determined by multiple factors. Despite this call to action, suicide prevention largely focuses on identifying and referring suicidal persons to mental health treatment and preventing reattempts (*6*). In addition to mental health conditions and prior suicide attempts, other contributing circumstances include social and economic problems, access to lethal means (e.g., substances, firearms) among persons at risk, and poor coping and problem-solving skills (*5*). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them can help reach the national goal, established by the National Action Alliance of Suicide Prevention and the American Foundation for Suicide Prevention, of reducing the annual suicide rate 20% by 2025 (*7*). To assist states in achieving this goal, CDC analyzed state-specific trends in suicide rates and assessed the multiple contributing factors to suicide; this report presents options for strategies to include in comprehensive suicide prevention efforts that are based on the best available evidence.

Methods

Suicide rates were analyzed for persons aged ≥10 years because determining suicidal intent in younger children can be difficult (*8*). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases, Tenth Revision,* underlying-cause-of death codes X60–X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive 3-year aggregate periods spanning 1999–2016 (1999–2001; 2002–2004; 2005–2007; 2008–2010; 2011–2013; and 2014–2016). Rate estimates were age-adjusted to the U.S. 2000 standard population and expressed

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per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same 3-year data aggregates, employing weighted least-squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes.

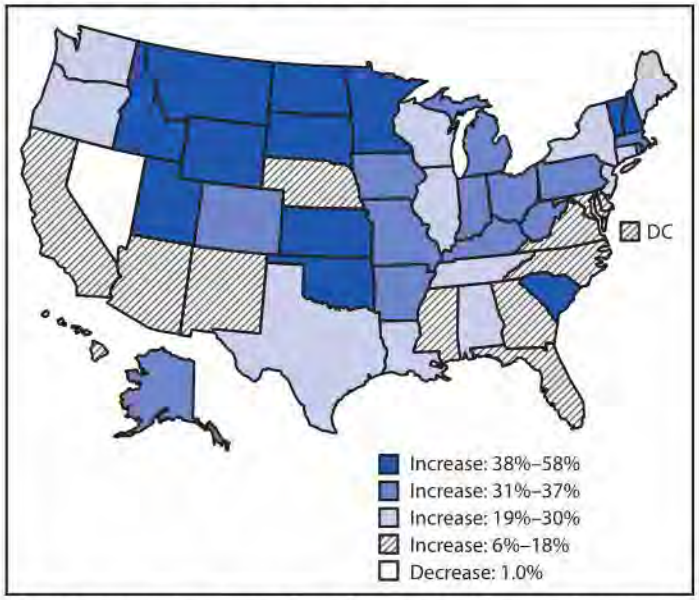
Characteristics of persons aged ≥10 years who died by suicide, with and without known mental health conditions, and the circumstances surrounding the suicides were compared in the 27 states* with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines mental health conditions as disorders and syndromes listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*9*), with the exception of problematic alcohol use and other substance use that are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. A range of circumstances (relationship problems, life stressors, and recent or impending crises) have been identified as potential risk factors for suicide in NVDRS. Circumstances captured are those identified as contributing to suicide in coroner/medical examiner or law enforcement reports, which reflect information provided by family and friends at the time of death. Decedents could have experienced multiple circumstances. Decedents with and without known mental health conditions were compared using chi-square tests. Logistic regression analyses were used to estimate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), controlling for sex, age group, and race/ethnicity.

Results

The most recent overall suicide rates (representing 2014–2016) varied fourfold, from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Across the study period, rates increased in all states except Nevada (where the rate was consistently high throughout the study period), with absolute increases ranging from 0.8 per 100,000 (Delaware) to 8.1 (Wyoming). Percentage increases in rates ranged from 5.9% (Delaware) to 57.6% (North Dakota), with increases >30% observed in 25 states (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785) (Figure).

Modeled suicide rate trends indicated significant increases in 44 states, among males (34 states) and females (43 states), as well as for the United States overall (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Nationally, the model-estimated average annual percentage change for the overall suicide rate was an increase of 1.5%. By sex, estimated national rate trends further indicated significant average annual percentage change increases for males (1.1%) and females (2.6%) (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785).

FIGURE. Percent change in annual suicide rate,* by state — United States, from 1999–2001 to 2014–2016



* Per 100,000 population, age-adjusted to the 2000 U.S. standard population.

Suicide decedents without known mental health conditions (11,039; 54.0%) were compared with those with known mental health conditions (9,407; 46.0%) for 27 states. Whereas decedents were predominantly male (76.8%) (Table 1) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely to be male (83.6% versus 68.8%; odds ratio [OR] = 2.3, 95% CI = 2.2–2.5) and belong to a racial/ethnic minority (OR range = 1.2–2.0). Suicide decedents without known mental health conditions also had significantly higher odds of perpetrating homicide followed by suicide (aOR = 2.9, 95% CI = 2.2–3.8). Among decedents aged ≥18 years, 20.1% of those without known mental health conditions and 15.3% of those with mental health conditions had previously served in the U.S. military or were serving at the time of death.

Whereas firearms were the most common method of suicide overall (48.5%), decedents without known mental health conditions were more likely to die by firearm (55.3%) and less likely to die by hanging/strangulation/suffocation (26.9%) or poisoning (10.4%) than were those with known mental health conditions (40.6%, 31.3%, and 19.8%, respectively). These differences remained significant in the adjusted models.

Toxicology testing was less likely to be performed for decedents without known mental health conditions. Among those with toxicology results, decedents without known mental health

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

TABLE 1. Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	**15,702 (76.8)**	6,469 (68.8)	9,233 (83.6)	<0.01	2.3 (2.2–2.5)	NA
Female	**4,744 (23.2)**	2,938 (31.2)	1,806 (16.4)	<0.01	0.4 (0.4–0.5)	NA
Age group (yrs)**						
10–24	**2,804 (13.7)**	1,211 (12.9)	1,593 (14.4)	<0.01	1.1 (1.1–1.2)	NA
25–44	**6,456 (31.6)**	3,036 (32.3)	3,420 (31.0)	<0.05	0.9 (0.9–1.0)	NA
45–64	**7,718 (37.7)**	3,820 (40.6)	3,898 (35.3)	<0.01	0.8 (0.8–0.8)	NA
≥65	**3,468 (17.0)**	1,340 (14.2)	2,128 (19.3)	<0.01	1.4 (1.3–1.5)	NA
Race/Ethnicity						
White, non-Hispanic	**17,102 (83.6)**	8,165 (86.8)	8,937 (81.0)	<0.01	0.6 (0.6–0.7)	NA
Black, non-Hispanic	**1,228 (6.0)**	411 (4.4)	817 (7.4)	<0.01	1.7 (1.5–2.0)	NA
American Indian/Alaska Native, non-Hispanic	**378 (1.8)**	112 (1.2)	266 (2.4)	<0.01	2.0 (1.6–2.6)	NA
Asian, non-Hispanic	**576 (2.8)**	235 (2.5)	341 (3.1)	<0.05	1.2 (1.1–1.5)	NA
Hispanic	**1,096 (5.4)**	463 (4.9)	633 (5.7)	<0.05	1.2 (1.0–1.3)	NA
Other	**66 (0.3)**	21 (0.2)	45 (0.4)	<0.05	1.8 (1.1–3.1)	NA
Extended demographics						
Ever served in military††	**3,429 (17.8)**	1,354 (15.3)	2,075 (20.1)	<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	**240 (1.2)**	104 (1.1)	136 (1.3)	NS	1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident type						
Single suicide	**20,063 (98.2)**	9,318 (99.1)	10,745 (97.4)	<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	**319 (1.6)**	64 (0.7)	255 (2.3)	<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	**64 (0.3)**	25 (0.3)	39 (0.4)	NS	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	**9,909 (48.5)**	3,821 (40.6)	6,088 (55.3)	<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	**5,907 (28.9)**	2,940 (31.3)	2,967 (26.9)	<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	**3,003 (14.7)**	1,861 (19.8)	1,142 (10.4)	<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	**1,021 (34.0)**	666 (35.8)	355 (31.1)	<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	**944 (31.4)**	608 (32.7)	336 (29.4)	NS	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	**800 (26.6)**	644 (34.6)	156 (13.7)	<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	**624 (20.8)**	468 (25.1)	156 (13.7)	<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	**219 (7.3)**	195 (10.5)	24 (2.1)	<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	**1,595 (7.8)**	780 (8.3)	815 (7.4)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)

See table footnotes on next page.

conditions were less likely to test positive for any substance overall (aOR = 0.8, 95% CI = 0.7–0.8), including opioids (aOR = 0.90, 95% CI = 0.81–0.99), but were more likely to test positive for alcohol (aOR = 1.2, 95%, CI = 1.1–1.3).

Information on circumstances surrounding suicide were available for all decedents with mental health conditions (9,407) and approximately 85% of those without known mental health conditions (9,357) in 27 states (Table 2). Persons without known mental health conditions were less likely to have any problematic substance use (aOR = 0.7, 95% CI = 0.7–0.8) than were persons with known mental health conditions. Whereas two thirds of decedents with known mental health conditions had a history of mental health or substance use treatment (67.2%), just over half (54.0%) were in treatment at the time of death.

Decedents without known mental health conditions had a significantly higher likelihood of any relationship problem/loss (45.1%) than did those with known mental health conditions (39.6%), specifically intimate partner problems (30.2% versus 24.1%), arguments/conflicts (17.5% versus 13.6%), and perpetrating interpersonal violence in the past month (3.0% versus 1.4%). Decedents without known mental health conditions were also more likely than were those with known mental health conditions to have experienced any life stressors (50.5% versus 47.2%) such as recent criminal legal problems (10.7% versus 6.2%) or eviction/loss of home (4.3% versus 3.4%) and were more likely to have had a recent or impending (within the preceding or upcoming 2 weeks, respectively) crisis (a current or acute event thought to contribute to the suicide) (32.9% versus 26.0%). All of these differences remained significant in the adjusted models. Physical health problems and job/financial problems were commonly contributing stressors among both persons without mental health conditions (23.2% and 15.6%, respectively) and those with mental health conditions (21.4%

TABLE 1. (*Continued*) Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Toxicology results						
Any toxicology testing	**13,317 (65.1)**	6,658 (70.8)	6,659 (60.3)	<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	**9,913 (74.4)**	5,192 (78.0)	4,721 (70.9)	<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected* **						
Alcohol						
Tested	**10,950 (53.6)**	5,409 (57.5)	5,541 (50.2)	<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	**4,442 (40.6)**	2,115 (39.1)	2,327 (42.0)	<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	**8,554 (41.8)**	4,258 (45.3)	4,296 (38.9)	<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	**2,279 (26.6)**	1,238 (29.1)	1,041 (24.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	**8,124 (39.7)**	4,226 (44.9)	3,898 (35.3)	<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	**2,464 (30.3)**	1,639 (38.8)	825 (21.2)	<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	**7,978 (39.0)**	3,866 (41.1)	4,112 (37.2)	<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	**499 (6.3)**	216 (5.6)	283 (6.9)	<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	**7,615 (37.2)**	3,696 (39.3)	3,919 (35.5)	<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	**736 (9.7)**	376 (10.2)	360 (9.2)	NS	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	**6,569 (32.1)**	3,127 (33.2)	3,442 (31.2)	<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	**1,471 (22.4)**	710 (22.7)	761 (22.1)	NS	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	**5,425 (26.5)**	3,103 (33.0)	2,322 (21.0)	<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	**2,214 (40.8)**	1,735 (55.9)	479 (20.6)	<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviations: CI = confidence interval; NA = not adjusted; NS = not significant; OR = odds ratio.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology testing.

*** Denominator for each positive group is the number tested for the substance in that group.

and 16.8%, respectively). Similarly, among all persons with recent crises, intimate partner problems were the most common types and did not differ by group.

Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR = 0.5, 95% CI = 0.4–0.5). Among those recently released, decedents without known mental health conditions were significantly more likely than decedents with mental health conditions to have been released from a correctional facility (25.7% versus 8.7%), hospital (43.7% versus 33.0%), or other facility, such as an alcohol/substance use treatment facility (24.2% versus 11.6%). Among decedents with known mental health conditions who were recently released from an institution, 46.7% were released from psychiatric facilities.

Decedents without known mental health conditions were significantly less likely to have a history of suicidal ideation (23.0%) or prior suicide attempts (10.3%) compared with those with known mental health conditions (40.8% and 29.4%, respectively). Suicide intent was disclosed by 22.4% and 24.5% of persons without and with known mental health conditions, respectively.

Conclusions and Comments

During 1999–2016, suicide rates increased significantly in 44 states, and 25 states experienced increases >30%. Rates increased significantly among males in 34 states, and females in 43 states. Additional research into the specific causes of these trends is needed. Data from the 27 states participating in NVDRS provide important insight into circumstances surrounding suicide and can help states identify prevention priorities.

TABLE 2. Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	**18,764 (91.8)**	9,407 (100)	9,357 (84.8)	<0.01	N/A	N/A
Mental health						
Any current diagnosed mental health condition**						
Depression/Dysthymia	—††	7,076 (75.2)	N/A	N/A	N/A	N/A
Anxiety disorder	—††	1,579 (16.8)	N/A	N/A	N/A	N/A
Bipolar disorder	—††	1,431 (15.2)	N/A	N/A	N/A	N/A
Schizophrenia	—††	509 (5.4)	N/A	N/A	N/A	N/A
PTSD	—††	424 (4.5)	N/A	N/A	N/A	N/A
ADD/ADHD	—††	226 (2.4)	N/A	N/A	N/A	N/A
Not specified	—††	760 (8.1)	N/A	N/A	N/A	N/A
Current depressed mood§§	**7,038 (37.5)**	3,962 (42.1)	3,076 (32.9)	<0.01	0.7 (0.6–0.7)	0.7 (0.6–0.7)
Problematic substance use						
Any	**5,319 (28.3)**	2,976 (31.6)	2,343 (25.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Alcohol	**3,268 (17.4)**	1,862 (19.8)	1,406 (15.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Other	**3,084 (16.4)**	1,768 (18.8)	1,316 (14.1)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Treatment						
Current mental health/substance use treatment	**5,141 (27.4)**	5,077 (54.0)	64 (0.7)	<0.01	0.01 (0.01–0.01)	0.01 (0.01–0.01)
Ever treated for mental health/substance disorder	**6,717 (35.8)**	6,323 (67.2)	394 (4.2)	<0.01	0.02 (0.02–0.02)	0.02 (0.02–0.03)
Relationship problems/loss						
Any relationship problem/loss	**7,948 (42.4)**	3,726 (39.6)	4,222 (45.1)	<0.01	1.3 (1.2–1.3)	1.3 (1.2–1.4)
Intimate partner problem	**5,098 (27.2)**	2,270 (24.1)	2,828 (30.2)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Perpetrator of interpersonal violence in past month	**414 (2.2)**	131 (1.4)	283 (3.0)	<0.01	2.2 (1.8–2.7)	2.0 (1.6–2.4)
Victim of interpersonal violence in past month	**84 (0.4)**	53 (0.6)	31 (0.3)	<0.05	0.6 (0.4–0.9)	0.8 (0.5–1.2)
Family relationship problem	**1,671 (8.9)**	873 (9.3)	798 (8.5)	NS	0.9 (0.8–1.0)	1.0 (0.9–1.1)
Other relationship problem (nonintimate)	**403 (2.1)**	202 (2.1)	201 (2.1)	NS	1.0 (0.8–1.2)	1.1 (0.9–1.3)
Argument or conflict (not specified)	**2,914 (15.5)**	1,278 (13.6)	1,636 (17.5)	<0.01	1.3 (1.2–1.5)	1.4 (1.3–1.5)
Death of a loved one (any)	**1,497 (8.0)**	826 (8.8)	671 (7.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–0.9)
Nonsuicide death	**1,181 (6.3)**	647 (6.9)	534 (5.7)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Suicide of family or friend	**379 (2.0)**	217 (2.3)	162 (1.7)	<0.01	0.7 (0.6–0.9)	0.8 (0.7–1.0)
Other life stressors						
Any life stressor	**9,171 (48.9)**	4,442 (47.2)	4,729 (50.5)	<0.01	1.1 (1.1–1.2)	1.1 (1.0–1.2)
Recent criminal legal problem	**1,588 (8.5)**	586 (6.2)	1,002 (10.7)	<0.01	1.8 (1.6–2.0)	1.7 (1.5–1.9)
Other legal problem	**748 (4.0)**	378 (4.0)	370 (4.0)	NS	1.0 (0.8–1.1)	1.0 (0.9–1.2)
Physical health problem	**4,179 (22.3)**	2,012 (21.4)	2,167 (23.2)	<0.01	1.1 (1.0–1.2)	1.0 (1.0–1.1)
Job/Financial problem¶¶	**2,941 (16.2)**	1,530 (16.8)	1,411 (15.6)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Eviction or loss of home	**722 (3.8)**	317 (3.4)	405 (4.3)	<0.01	1.3 (1.1–1.5)	1.4 (1.2–1.6)
School problem***	**162 (19.9)**	70 (17.8)	92 (21.9)	NS	1.3 (0.9–1.8)	1.3 (0.9–1.9)
Recent release from an institution†††	**1,412 (7.6)**	941 (10.2)	471 (5.1)	<0.01	0.5 (0.4–0.5)	0.5 (0.4–0.5)
Jail/Prison/Detention facility	**203 (14.4)**	82 (8.7)	121 (25.7)	<0.01	3.6 (2.7–4.9)	4.5 (3.2–6.4)
Hospital	**517 (36.6)**	311 (33.0)	206 (43.7)	<0.01	1.6 (1.3–2.0)	1.3 (1.0–1.7)
Psychiatric hospital/institution	**469 (33.2)**	439 (46.7)	30 (6.4)	<0.01	0.1 (0.1–0.1)	0.1 (0.1–0.1)
Other (includes alcohol/SU treatment facilities)	**223 (15.8)**	109 (11.6)	114 (24.2)	<0.01	2.4 (1.8–3.3)	2.5 (1.8–3.3)

See table footnotes on next page.

Suicidologists regularly state that suicide is not caused by a single factor (*5*); however, suicide prevention is often oriented toward mental health conditions alone with regard to downstream identification of suicidal persons, treatment of mental health conditions, and prevention of reattempts. This study found that approximately half of suicide decedents in NVDRS did not have a known mental health condition, indicating that additional focus on nonmental health factors further upstream could provide important information for a public health approach (*10*). Those without a known mental health condition suffered more from relationship problems and other life stressors such as criminal/legal matters, eviction/loss of home, and recent or impending crises.

Similarly, persons with mental health conditions also often experienced other circumstances such as relationship problems and job/financial or physical health problems that contributed to their suicide. These findings point to the need to both prevent the circumstances associated with the onset of mental health conditions and support persons with known mental health conditions to decrease their risk for poor outcomes (*11*). Two thirds of suicide decedents with mental health conditions had a history of treatment for mental health or substance use disorders,

TABLE 2. (*Continued*) Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Crisis within past or upcoming 2 weeks§§§	**5,525 (29.4)**	2,444 (26.0)	3,081 (32.9)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Intimate partner problem	**1,968 (35.6)**	854 (34.9)	1,114 (36.2)	NS	1.1 (0.9–1.2)	1.1 (0.9–1.2)
Physical health problem	**739 (13.4)**	315 (12.9)	424 (13.8)	NS	1.1 (0.9–1.3)	1.0 (0.8–1.2)
Criminal legal problem	**621 (11.2)**	203 (8.3)	418 (13.6)	<0.01	1.7 (1.5–2.1)	1.6 (1.3–1.9)
Family relationship problem	**430 (7.8)**	212 (8.7)	218 (7.1)	<0.05	0.8 (0.7–1.0)	0.9 (0.7–1.1)
Job problem	**354 (6.4)**	191 (7.8)	163 (5.3)	<0.01	0.7 (0.5–0.8)	0.7 (0.5–0.8)
Suicide event/history						
Left a note	**6,468 (34.5)**	3,182 (33.8)	3,286 (35.1)	NS	1.1 (1.0–1.1)	1.2 (1.1–1.2)
Disclosed suicide intent	**4,405 (23.5)**	2,306 (24.5)	2,099 (22.4)	<0.01	0.9 (0.8–1.0)	0.9 (0.8–0.9)
History of ideation	**5,990 (31.9)**	3,838 (40.8)	2,152 (23.0)	<0.01	0.4 (0.4–0.5)	0.4 (0.4–0.5)
History of attempts	**3,732 (19.9)**	2,770 (29.4)	962 (10.3)	<0.01	0.3 (0.3–0.3)	0.3 (0.3–0.3)

Abbreviations: ADD/ADHD = attention deficit disorder/attention deficit hyperactivity disorder; CI = confidence interval; N/A = not applicable; NS = not significant; OR = odds ratio; PTSD = posttraumatic stress disorder; SU = substance use.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was the reference group.

** Includes decedents with one or more diagnosed current mental health conditions, which are not mutually exclusive. Therefore, sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health conditions.

†† The specific type of mental health condition was calculated only among those with one or more known diagnosed mental health conditions.

§§ Not a diagnosis.

¶¶ Denominator is decedents aged ≥18 years.

*** Denominator is decedents aged 10–18 years.

††† Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.

§§§ Denominator of crisis subgroup is decedents with any crisis within past or upcoming 2 weeks. Crises depicted here represent the most commonly occurring categories.

with approximately half in treatment when they died. This finding suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities, such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. In addition, increased access to behavioral health providers in underserved areas is needed, as is expansion of health care systems that integrate physical and behavioral health, with a priority on suicide prevention and patient safety, especially through care transitions (*12*).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belonging and access to informational, tangible, emotional, and social support; and identifying and better supporting persons at risk (e.g., military veterans, persons with physical/mental health conditions) (*12*). Other strategies include creating protective environments (e.g., reducing access to lethal means among persons at risk for suicide, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for persons with mental health conditions and other life challenges), strengthening access to and delivery of care, supporting family and friends after a suicide, and encouraging the media to follow safe reporting recommendations (*12*). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (*10*).

The findings in this report are subject to at least three limitations. First, in the state-level analysis, rankings for four states (Maryland, Massachusetts, Rhode Island, and Utah) might have been affected by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward) or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml). Finally, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies that include more in-depth interviews with next-of-kin often identify greater attributions to mental health disorders

Summary

What is already known about this topic?

In 2016, nearly 45,000 persons died by suicide in the United States. Mental health conditions are one of several contributors to suicide.

What is added by this report?

During 1999–2016, suicide rates increased in nearly every state, including >30% increases in 25 states. 2015 data from 27 states indicate 54% of suicide decedents were not known to have mental health conditions. Relationship, substance use, health, and job or financial problems are among the other circumstances contributing to suicide.

What are the implications for public health practice?

A comprehensive approach using proven prevention strategies, such as those in CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, can help reach the national goal of reducing the annual suicide rate 20% by 2025.

(*13*); however, many methodological variations across studies exist (*14*). It is likely that some persons without known mental health conditions in the current study were experiencing mental health challenges that were unknown, undiagnosed, or not reported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (*12*) to better understand suicide in their populations, prioritize evidence-based comprehensive suicide prevention, and save lives.

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Conflict of Interest

No conflicts of interest were reported.

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Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

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State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30 ¶¶)	+ 34.1 % (23 ¶¶)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3 ¶¶)	+ 46.5 % (4 ¶¶)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Different ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Different ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Different ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

State Abbreviations: AL Alabama; AK Alaska; AZ Arizona; AR Arkansas; CA California; CO Colorado; CT Connecticut; DE Delaware; DC District of Columbia; FL Florida; GA Georgia; HI Hawaii; ID Idaho; IL Illinois; IN Indiana; IA Iowa; KS Kansas; KY Kentucky; LA Louisiana; ME Maine; MD Maryland; MA Massachusetts; MI Michigan; MN Minnesota; MS Mississippi; MO Missouri; MT Montana; NE Nebraska; NV Nevada; NH New Hampshire; NJ New Jersey; NM New Mexico; NY New York; NC North Carolina; ND North Dakota; OH Ohio; OK Oklahoma; OR Oregon; PA Pennsylvania; RI Rhode Island; SC South Carolina; SD South Dakota; TN Tennessee; TX Texas; UT Utah; VT Vermont; VA Virginia; WA Washington; WV West Virginia; WI Wisconsin; WY Wyoming.

From: Sokler, Lynn (CDC/OD/OADC)
Sent: 20 Apr 2018 14:26:25 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Sokler, Lynn (CDC/OD/OADC);Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID);Peaker, Brandy (CDC/OPHSS/CSELS/DPHID);Omisore, Shannon L. (CDC/OD/OADC)
Subject: FW: June Vital Signs - Suicide Prevention - MMWR early draft
Attachments: MMWR Text_V1_4.10.18_4.30pm DS.docx, MMWR Tables_V1_4.10.18_4.30pm DS.docx

Hi Folks,
Just wanted you to know that Dr. Redfield asked for a copy of the MMWR now so that he can determine whether he or Anne Schuchat will do the Telebriefing.
Either one is probably a good thing!
Will keep you posted.
Lynn

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, April 20, 2018 2:21 PM
To: Daniel, Katherine Lyon (CDC/OD/OADC)

Subject: June Vital Signs - Suicide Prevention - MMWR early draft
This is an early draft of the MMWR.
Currently, the pre-brief with Anne is set up for May 8.
To accommodate her travel schedule we set up the media telebrief and launch of the Vital Signs for Thursday, June 7. Invites have been issued.
If Dr. Redfield is able to and wants to do this one, is it possible to change to our normal Tuesday, June 5 schedule? FYI and isn't any deciding factor at all, but I am on leave and on a plane on June 7, but I am here on June 5.
Please let us know,
Thanks, Lynn

Short Title: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Deborah M. Stone, ScD;[1] Thomas R. Simon PhD;[1] Katherine A. Fowler, PhD;[1] Scott R. Kegler, PhD;[2] Keming Yuan, MS;[1] Kristin M. Holland, PhD;[1] Asha Z. Ivey-Stephenson, PhD;[1] Alex E. Crosby, MD[1]

Background: Suicide rates in the United States have risen nearly 30% since 1999. Mental health problems (MHP) are just one factor contributing to suicide. Examining state-level trends in, and the multiple contributing circumstances to, suicide can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among people aged ≥10 years, by state and sex, across six consecutive three-year periods (1999-2016), were assessed using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health problems (MHP).

Results: From 1999-2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases of more than 30%. Rates increased significantly among males and females in 34 and 43 states, respectively. In 2015, more than half (54%) of decedents in 27 states did not have a known MHP. Among people with circumstance information, several circumstances, including relationship problems/loss (45.1% vs 39.6%), life stressors (54.2% vs 49.7%), and recent/impending crises (32.9% vs 26.0%) were significantly more likely among those without a known MHP than decedents with MHP, but were common across groups.

Conclusions: Suicide rates increased significantly across most states from 1999-2016. Various circumstances contributed to suicides among people with and without known MHP.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support people at risk, prevent reattempts, and help friends/family after a suicide occurs.

INTRODUCTION

BACKGROUND AND PURPOSE

In 2016, nearly 45,000 suicides (15.6/100,000 [age-adjusted]) occurred in the United States (U.S.), among people ≥10 years old (1). Between 1999 and 2015, suicide rates increased across sexes, racial/ethnic groups, and urbanization levels (2, 3). Suicide is the 10th leading cause of death and is one of just three leading causes that are *increasing* (1, 4). Additionally, rates of emergency department visits for nonfatal self-harm, a key risk factor for suicide, increased nearly 45% between 2001 and 2015 (1). Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs (1).

The *National Strategy for Suicide Prevention(NSSP)* (5) calls for a public health approach to suicide prevention with efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is multi-determined. Despite the NSSP guidance, suicide prevention largely focuses on identifying suicidal people, providing treatment for mental health problems (MHP) and preventing re-attempts (6). In addition to MHP and prior attempts, other contributing circumstances to suicide include social and economic problems, access to lethal means (e.g., substances, firearms) among people at risk, and poor coping and problem-solving skills (5). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them, can help reach the nation's goal of reducing suicide rates 20% by 2025 (7). To assist states in achieving this goal,

this study analyzes state-specific trends in suicide rates, assesses the multiple contributing factors to suicide, and provides options for multi-level comprehensive suicide prevention based on the best available evidence.

METHODS

Suicide rates were analyzed for people aged ≥10 years only, as determining suicidal intent in younger children can be difficult (8). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases 10th Revision,* underlying-cause-of death codes X60-X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive three-year aggregate periods spanning 1999-2016. Rate estimates were age-adjusted to the U.S. year 2000 standard population and expressed per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same three-year data aggregates, employing weighted least squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes (AAPCs).

Characteristics and circumstances of suicide decedents ≥10 years old, with and without known MHP, were compared in the 27 states with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines MHP as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (9), with the exception of alcohol and other substance dependence, which are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. Decedents with and without known MHP were compared using Chi-square tests. Logistic regression analyses estimated adjusted odds ratios with 95% confidence intervals (CI), controlling for age group, sex, and race/ethnicity.

RESULTS

The most recent overall suicide rates (representing 2014-2016) varied four-fold, from 6.9 (D.C.) to 29.2 (Montana) per 100,000 persons per year (Table 1). Across the study period, rates increased in all states, except Nevada (which had a consistently high rate throughout), with absolute increases ranging from +0.8 (Delaware) to +8.1 (Wyoming) per 100,000. Percentage increases in rates ranged from +5.9% (Delaware) to +57.6% (North Dakota), with increases of more than 30% observed in 25 states (Table 1, Figure 1).

Modeled suicide rate trends indicated significant increases for 44 states, for males (34 states) and females (43 states), as well as for the U.S. overall (Table 1). Nationally, the model-estimated AAPC for the overall suicide rate was +1.5%. By sex, estimated national rate trends further indicated significant increases for males (AAPC +1.1%) and females (AAPC +2.6%).

Suicide decedents without known MHP (N=11,039) were compared to those with MHP (N=9,407) in 27 states. While all decedents were predominately male (Table 2; 76.8%) and non-Hispanic white (83.6%), those without known MHP, relative to those with MHP, were more likely male (83.6% vs. 68.8%; odds ratio (OR)=2.3, 95% CI = 2.2-2.5) and racial/ethnic minorities (OR range: 1.2-2.0). Suicide decedents without known MHP also had significantly greater odds of perpetrating homicide-suicide (adjusted odds ratio aOR = 2.9, 95% CI = 2.2-3.8). Among adult decedents, 20.1% of those without known MHP and 15.3% of those with MPH ever served, or were currently serving, in the U.S. military.

While firearms were the most common method of suicide used overall (48.5%) and for both groups, decedents without known MHP were more likely to die by firearm (55.3% vs. 40.6%) and less likely to die by

hanging/strangulation/suffocation (26.9% vs 31.3%) or poisoning (10.4% vs 19.8%) than those with known MHP. These differences remained significant in the adjusted models.

Decedents without known MHP were less likely to receive toxicology testing. Among those with toxicology results, decedents without known MHP were less likely to test positive for any substance overall (aOR=0.8, 95% CI=0.7-0.8), such asopioids (aOR=.90 95% CI=0.81-.99) but more likely to test positive for alcohol (aOR=1.2, 95% CI=1.1-1.3).

All suicide decedents with MHP (N=9,407) and approximately 85% without known MHP (N=9,357) had available circumstances information (Table 3). People without known MHP were less likely to have any substance abuse problems (aOR=0.7, 95% CI=0.7-0.8). While two-thirds of those with known MHP had a history of mental health or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment.

Decedents without, versus those with, known MHP, had significantly greater likelihood of any relationship problem/loss (45.1% vs. 39.6%), specifically intimate partner problems (30.2% vs. 24.1%), arguments/conflicts (17.5% vs. 13.6%), and recently perpetrating interpersonal violence (3.0% vs. 1.4%). They also were more likely to have experienced any life stressors (54.2% vs 49.7%), such as criminal-legal problems (10.7% vs. 6.2%), or eviction/loss of home (4.3% vs. 3.4%) and were more likely to have had a crisis within the preceding or upcoming two weeks (32.9% vs. 26.0%). All of these differences remained significant in the adjusted models. Among all people with crises, intimate partner problems were the most common types and did not differ by group. Similarly, among people without versus with MHP, physical health problems (23.2% and 21.4%) and job/financial problems (15.6% and 16.8%) were commonly experienced by both groups.

Decedents without known MHP had significantly lower odds of recent release from any institution (aOR=0.5, 95% CI=0.4-0.5), but among those who were recently released (5.1%), they were significantly more likely to be released from a correctional facility (25.7% vs. 8.7%), hospital (43.7% vs. 33.0%), or other facility (e.g., alcohol/substance treatment) (aOR=2.5 95% CI=1.8-3.3), than those with a known MHP. Among decedents with known MHP who were recently released from an institution (10.2%), 46.7% of this group were released from psychiatric facilities.

Decedents without known MHP, compared to those with MHP, were significantly less likely to have a history of suicidal ideation (23.0% vs. 40.8%) and prior suicide attempts (10.3% vs. 29.4%). More than one in five people in both groups disclosed suicide intent (22.4% vs. 24.5%).

Conclusions and Comments

From 1999-2016, 44 states saw significant increases in suicide rates and 25 states experienced substantial increases in suicide rates of more than 30%. Rates increased significantly among males, in 34 states, and females, in 43 states. This finding is consistent with prior research showing a decreasing gender gap in male-female suicide rates between 1999-2014 (3). Additional research into the specific causes of these trends is necessary. Fortunately, data from the 27 states participating in NVDRS provides important insight into suicide circumstances and can help states identify prevention priorities.

Suicidologists regularly state that suicide is not caused by a single factor; (5) however, suicide prevention is often oriented towards downstream identification of suicidal people, treatment of MHP and prevention of reattempts. Additional focus on non-mental health factors, further upstream, is essential to a public health approach (10), as the current study found that more than half of suicide decedents in NVDRS did *not* have a known MHP. This group suffered more from relationship problems and other life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises.

Similarly, people with MHP often experienced relationship problems and other life stressors such as job/financial and/or physical health problems. These findings point to the need to both help people manage the conditions associated with mental health problems in the first place, and to support people with known MHP to decrease their risk of poor outcomes (11). Two-thirds of this group had a history of any mental health and/or substance abuse treatment, with over half in treatment when they died. This suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to behavioral health providers in underserved areas is needed, as is expansion of healthcare systems needed that integrates physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions (12).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include: strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belongingness and access to informational, tangible, emotional, and social support; and identifying and better supporting people at risk (e.g., Veterans, people with physical/mental health problems) (12). Other strategies include creating protective environments (e.g., reducing access to lethal means among people at risk, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for people with MHP and other life challenges), supporting family and friends after a suicide, and assuring safe reporting by the media in order to prevent suicide contagion (12). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (10).

These findings have at least three limitations. In the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward), or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml).

Third, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can impact data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often see greater attributions to mental disorders (13), however many methodological variations across studies exist (14). It is likely that some people without known MHP in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known MHP suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices* (12) to better understand their suicide problem, prioritize evidence-based comprehensive suicide prevention, and save lives.

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Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Differences between ranks do not necessarily imply a statistically significant difference.

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** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

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		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

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§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

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Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

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		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30 ¶¶)	+ 34.1 % (23 ¶¶)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3 ¶¶)	+ 46.5 % (4 ¶¶)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

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		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Differences between ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

Figure 1

Percentage Changes in Annual Suicide Rates (per 100,000, Age-Adjusted)

2014-2016 Compared Against 1999-2001

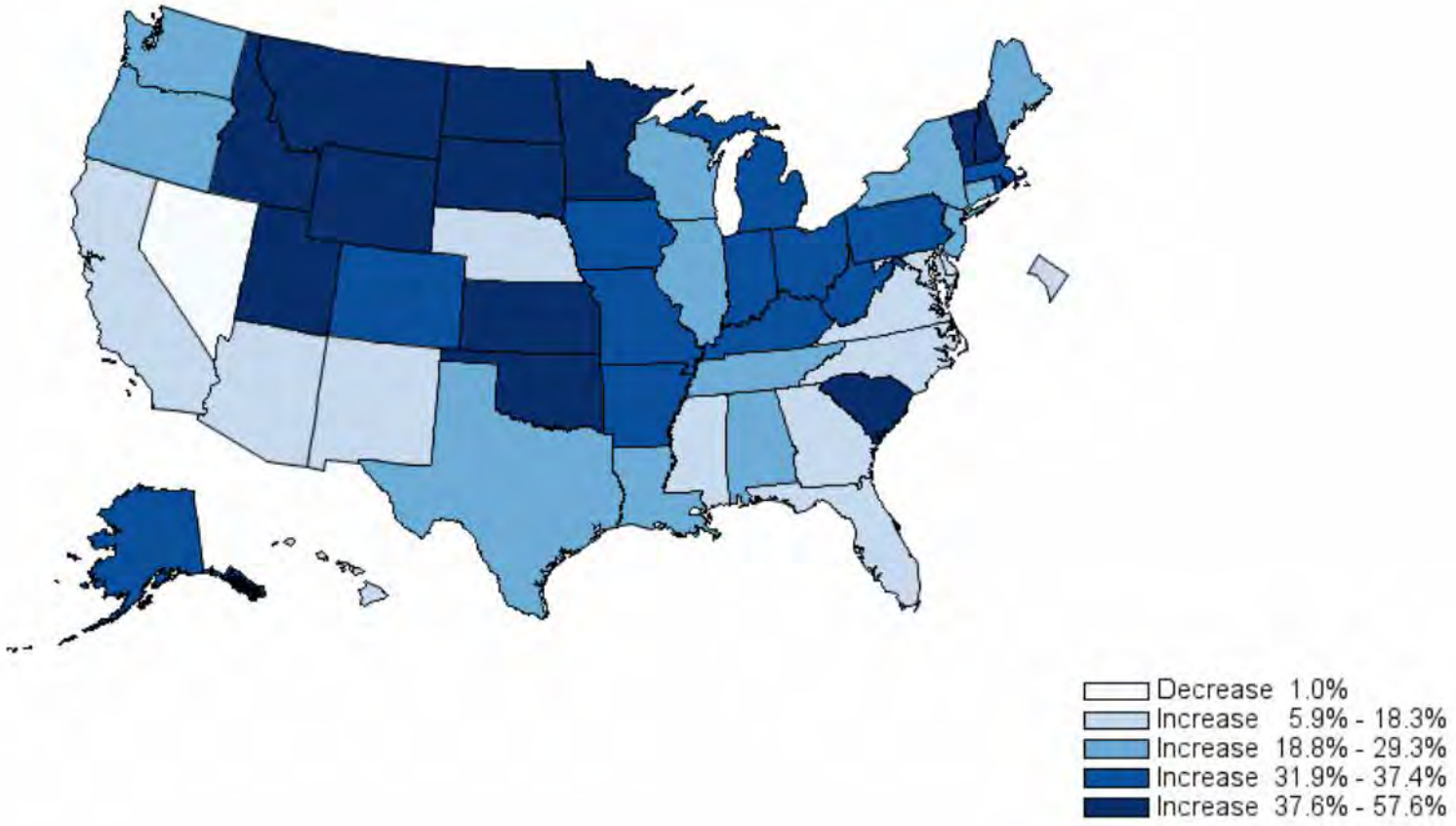


Table 2. Select Demographic and Descriptive Characteristics of Suicides among Decedents ≥10 years of age with and without Known Mental Health Problems--National Violent Death Reporting System, 27 states*, 2015

Characteristics	Total (n=20,446)	Mental Health Problem† (n=9,407)	No Known Mental Health Problem (n=11,039)	Chi-Square	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	15,702(76.8)	6,469(68.8)	9,233(83.6)	p<.01	2.3(2.2-2.5)	
Female	4,744(23.2)	2,938(31.2)	1,806(16.4)	p<.01	0.4(0.4-0.5)	
Age**						
10-24	2,804(13.7)	1,211(12.9)	1,593(14.4)	p<.01	1.1(1.1-1.2)	
25-44	6,456(31.6)	3,036(32.3)	3,420(31.0)	p<.05	0.9(0.9-1.0)	
45-64	7,718(37.7)	3,820(40.6)	3,898(35.3)	p<.01	0.8(0.8-0.8)	
65+	3,468(17.0)	1,340(14.2)	2,128(19.3)	p<.01	1.4(1.3-1.5)	
Race/ethnicity						
White, non-Hispanic	17,102(83.6)	8,165(86.8)	8,937(81.0)	p<.01	0.6(0.6-0.7)	
Black, non-Hispanic	1,228(6.0)	411(4.4)	817(7.4)	p<.01	1.7(1.5-2.0)	
American Indian/Alaska Native, non-Hispanic	378(1.8)	112(1.2)	266(2.4)	p<.01	2.0(1.6-2.6)	
Asian, non-Hispanic	576(2.8)	235(2.5)	341(3.1)	p<.05	1.2(1.1-1.5)	
Hispanic	1,096(5.4)	463(4.9)	633(5.7)	p<.05	1.2(1.0-1.3)	
Other	66(0.3)	21(0.2)	45(0.4)	p<.05	1.8(1.1-3.1)	
Extended demographics						
Ever served in military††	3,429(17.8)	1,354(15.3)	2,075(20.1)	p<.01	1.4(1.3-1.5)	1.1(1.0-1.1)
Homeless	240(1.2)	104(1.1)	136(1.3)		1.1(0.9-1.5)	1.2(0.9-1.5)
Incident Type						
Single suicide	20,063(98.2)	9,318(99.1)	10,745(97.4)	p<.01	0.3(0.3-0.4)	0.4(0.3-0.5)
Homicide followed by suicide	319(1.6)	64(0.7)	255(2.3)	p<.01	3.5(2.6-4.5)	2.9(2.2-3.8)
Multiple suicides	64(0.3)	25(0.3)	39(0.4)		1.3(0.8-2.2)	1.6(0.9-2.6)
Method						
Firearm	9,909(48.5)	3,821(40.6)	6,088(55.3)	p<.01	1.8(1.7-1.9)	1.6(1.5-1.7)
Hanging/Strangulation/Suffocation	5,907(28.9)	2,940(31.3)	2,967(26.9)	p<.01	0.8(0.8-0.9)	0.8(0.7-0.8)

Poisoning		3,003(14.7)	1,861(19.8)	1,142(10.4)	p<.01	0.5(0.4-0.5)	0.6(0.6-0.7)
Substance class causing death[§§]							
Other (e.g., over-the-counter)		1,021(34.0)	666(35.8)	355(31.1)	p<.01	0.8(0.7-0.9)	0.9(0.7-1.0)
Opioids		944(31.4)	608(32.7)	336(29.4)		0.9(0.7-1.0)	0.9(0.8-1.1)
Antidepressants		800(26.6)	644(34.6)	156(13.7)	p<.01	0.3(0.2-0.4)	0.3(0.3-0.4)
Benzodiazepines		624(20.8)	468(25.1)	156(13.7)	p<.01	0.5(0.4-0.6)	0.5(0.4-0.6)
Antipsychotics		219(7.3)	195(10.5)	24(2.1)	p<.01	0.2(0.1-0.3)	0.2(0.1-0.3)
Other		1,595(7.8)	780(8.3)	815(7.4)	p<.05	0.9(0.8-1.0)	0.9(0.8-1.0)
Toxicology Results							
Any toxicology testing		13,317(65.1)	6,658(70.8)	6,659(60.3)	p<.01	0.6(0.6-0.7)	0.7(0.6-0.7)
Positive for ≥ 1 substance[¶¶]		9,913(74.4)	5,192(78.0)	4,721(70.9)	p<.01	0.7(0.6-0.7)	0.8(0.7-0.8)
Substance detected***							
Alcohol							
	Tested	10,950(53.6)	5,409(57.5)	5,541(50.2)	p<.01	0.7(0.7-0.8)	0.8(0.7-0.8)
	Positive	4,442(40.6)	2,115(39.1)	2,327(42.0)	p<.01	1.1(1.0-1.2)	1.2(1.1-1.3)
Opioids							
	Tested	8,554(41.8)	4,258(45.3)	4,296(38.9)	p<.01	0.8(0.7-0.8)	0.8(0.8-0.9)
	Positive	2,279(26.6)	1,238(29.1)	1,041(24.2)	p<.01	0.8(0.7-0.9)	0.9(0.8-.99)
Benzodiazepines							
	Tested	8,124(39.7)	4,226(44.9)	3,898(35.3)	p<.01	0.7(0.6-0.7)	0.7(0.7-0.8)
	Positive	2,464(30.3)	1,639(38.8)	825(21.2)	p<.01	0.4(0.4-0.5)	0.5(0.5-0.6)
Cocaine							
	Tested	7,978(39.0)	3,866(41.1)	4,112(37.2)	p<.01	0.9(0.8-0.9)	0.9(0.9-1.0)
	Positive	499(6.3)	216(5.6)	283(6.9)	p<.05	1.2(1.0-1.5)	1.2(1.0-1.5)
Amphetamines							
	Tested	7,615(37.2)	3,696(39.3)	3,919(35.5)	p<.01	0.9(0.8-0.9)	0.9(0.8-0.9)
	Positive	736(9.7)	376(10.2)	360(9.2)		0.9(0.8-1.0)	1.0(0.8-1.1)
Marijuana							
	Tested	6,569(32.1)	3,127(33.2)	3,442(31.2)	p<.01	0.9(0.9-1.0)	0.9(0.9-1.0)
	Positive	1,471(22.4)	710(22.7)	761(22.1)		1.0(0.9-1.1)	0.9(0.8-1.0)
Antidepressants							
	Tested	5,425(26.5)	3,103(33.0)	2,322(21.0)	p<.01	0.5(0.5-0.6)	0.6(0.6-0.7)
	Positive	2,214(40.8)	1,735(55.9)	479(20.6)	p<.01	0.2(0.2-0.2)	0.2(0.2-0.3)

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health problem in coroner/medical examiner or law enforcement reports.

§ Odds ratio reflects the risk among those without known mental health problem relative to those with known MHP.

¶ Logistic regression was used to estimate adjusted odds ratio with 95% CIs after controlling for age, sex, race and ethnicity. Known MHP was used as the reference group.

** Decedents were aged 10 years and older, as per standard in the suicide prevention literature.

†† Denominator is decedents aged 18 years of age and older with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology tested.

*** Denominator for each positive group is the number tested for the substance in that group.

Table 3. Circumstances Preceding Suicide among Decedents ≥10 years of age with and without Known Mental Health Problems--National Violent Death Reporting System, 27 states*, 2015

Characteristics	Total	Mental Health Problem†	No Known Mental Health Problem	Chi-Square	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	18,764(91.8)	9,407(100)	9,357(84.8)	p<.01		
Mental Health						
Any Current Diagnosed Mental Health Problem**						
Depression/dysthymia		7,076(75.2)				
Anxiety disorder		1,579(16.8)				
Bipolar disorder		1,431(15.2)				
Schizophrenia		509(5.4)				
PTSD		424(4.5)				
ADD/ADHD		226(2.4)				
Unknown		760(8.1)				
Current depressed mood		3,962(42.1)	3,076(32.9)	p<.01	0.7(0.6-0.7)	0.7(0.6-0.7)
Substance Problems						
Any Current substance problem	5,319(28.3)	2,976(31.6)	2,343(25.0)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Alcohol problem	3,268(17.4)	1,862(19.8)	1,406(15.0)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Other substance problem	3,084(16.4)	1,768(18.8)	1,316(14.1)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Treatment						
Current mental health/substance abuse treatment	5,141(27.4)	5,077(54.0)	64(0.7)	p<.01	0.01(0.01-0.01)	0.01(0.01-0.01)
Ever treated for mental health/substance problem	6,717(35.8)	6,323(67.2)	394(4.2)	p<.01	0.02(0.02-0.02)	0.02(0.02-0.03)
Relationship Problems/Loss						
Any relationship problem/loss	7,948(42.4)	3,726(39.6)	4,222(45.1)	p<.01	1.3(1.2-1.3)	1.3(1.2-1.4)
Intimate partner problem	5,098(27.2)	2,270(24.1)	2,828(30.2)	p<.01	1.4(1.3-1.5)	1.4(1.3-1.5)
Perpetrator of interpersonal violence past month	414(2.2)	131(1.4)	283(3.0)	p<.01	2.2(1.8-2.7)	2.0(1.6-2.4)
Victim of interpersonal violence within past month	84(0.4)	53(0.6)	31(0.3)	p<.05	0.6(0.4-0.9)	0.8(0.5-1.2)
Family relationship problem	1,671(8.9)	873(9.3)	798(8.5)		0.9(0.8-1.0)	1.0(0.9-1.1)

Other relationship problem (non-intimate)	403(2.1)	202(2.1)	201(2.1)		1.0(0.8-1.2)	1.1(0.9-1.3)
Argument or conflict (not specified)	2,914(15.5)	1,278(13.6)	1,636(17.5)	p<.01	1.3(1.2-1.5)	1.4(1.3-1.5)
Death of a loved one (any)	1,497(8.0)	826(8.8)	671(7.2)	p<.01	0.8(0.7-0.9)	0.9(0.8-0.9)
Non-suicide death	1,181(6.3)	647(6.9)	534(5.7)	p<.01	0.8(0.7-0.9)	0.9(0.8-1.0)
Suicide of family or friend	379(2.0)	217(2.3)	162(1.7)	p<.01	0.7(0.6-0.9)	0.8(0.7-1.0)
Other Life Stressors						
Any life stressor	9,743(51.9)	4,675(49.7)	5,068(54.2)	p<.01	1.2(1.1-1.3)	1.1(1.1-1.2)
Recent criminal legal problem	1,588(8.5)	586(6.2)	1,002(10.7)	p<.01	1.8(1.6-2.0)	1.7(1.5-1.9)
Other legal problem	748(4.0)	378(4.0)	370(4.0)		1.0(0.8-1.1)	1.0(0.9-1.2)
Physical health problem	4,179(22.3)	2,012(21.4)	2,167(23.2)	p<.01	1.1(1.0-1.2)	1.0(1.0-1.1)
Job/Financial problem††	2941(16.2)	1530(16.8)	1411(15.6)	p<.05	0.9(0.8-1.0)	0.9(0.8-1.0)
Eviction or loss of home	722(3.8)	317(3.4)	405(4.3)	p<.01	1.3(1.1-1.5)	1.4(1.2-1.6)
School problem§§	162(19.9)	70(17.8)	92(21.9)		1.3(0.9-1.8)	1.3(0.9-1.9)
Recent release from an institution¶¶	1,412(7.6)	941(10.2)	471(5.1)	p<.01	0.5(0.4-0.5)	0.5(0.4-0.5)
Jail/prison/detention facility	203(14.4)	82(8.7)	121(25.7)	p<.01	3.6(2.7-4.9)	4.5(3.2-6.4)
Hospital	517(36.6)	311(33.0)	206(43.7)	p<.01	1.6(1.3-2.0)	1.3(1.0-1.7)
Psychiatric hospital/institution	469(33.2)	439(46.7)	30(6.4)	p<.01	0.1(0.1-0.1)	0.1(0.1-0.1)
Other (includes alc/SA treatment facilities)	223(15.8)	109(11.6)	114(24.2)	p<.01	2.4(1.8-3.3)	2.5(1.8-3.3)
Recent or Impending Crisis						
Crisis within past or upcoming two weeks***	5,525(29.4)	2,444(26.0)	3,081(32.9)	p<.01	1.4(1.3-1.5)	1.4(1.3-1.5)
Intimate partner problem crisis	1968(35.6)	854(34.9)	1114(36.2)		1.1(0.9-1.2)	1.1(0.9-1.2)
Physical health problem crisis	739(13.4)	315(12.9)	424(13.8)		1.1(0.9-1.3)	1.0(0.8-1.2)
Criminal legal problem crisis	621(11.2)	203(8.3)	418(13.6)	p<.01	1.7(1.5-2.1)	1.6(1.3-1.9)
Family relationship problem crisis	430(7.8)	212(8.7)	218(7.1)	p<.05	0.8(0.7-1.0)	0.9(0.7-1.1)
Job problem crisis	354(6.4)	191(7.8)	163(5.3)	p<.01	0.7(0.5-0.8)	0.7(0.5-0.8)
Suicide Event/History						
Left a note	6,468(34.5)	3,182(33.8)	3,286(35.1)		1.1(1.0-1.1)	1.2(1.1-1.2)
Disclosed suicide intent	4,405(23.5)	2,306(24.5)	2,099(22.4)	p<.01	0.9(0.8-1.0)	0.9(0.8-0.9)
History of ideation	5,990(31.9)	3,838(40.8)	2,152(23.0)	p<.01	0.4(0.4-0.5)	0.4(0.4-0.5)
History of attempts	3,732(19.9)	2,770(29.4)	962(10.3)	p<.01	0.3(0.3-0.3)	0.3(0.3-0.3)

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health problem in coroner/medical examiner or law enforcement reports.

[§] Odds ratio reflects the risk among those without known mental health problem relative to those with known MHP.

[¶] Logistic regression was used to estimate adjusted odds ratio with 95% CIs after controlling for age, sex, race and ethnicity. Known MHP was used as the reference group.
[**] Includes decedents with one or more diagnosed current mental health problems, which are not mutually exclusive. Therefore sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health problems.

[††] Denominator is decedents aged 18 years of age and older.

[§§] Denominator is decedents aged 10-18 years.

[¶¶] Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.
[***] Denominator of crisis subgroup is decedents with any crisis within past or upcoming two weeks. Crises depicted here represent the most commonly occurring categories.

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: 25 May 2018 10:50:18 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Ballman, Marie R. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Black, Erin (CDC/ONDIEH/NCIPC);Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC);Lenard, Courtney (CDC/ONDIEH/NCIPC)
Subject: FW: Note on the upcoming Vital Signs
Attachments: VS summary for family ld ds2.docx

FYI. Note edited Q&A—please update the Q&A file you have.

From: Guest, Megan (CDC/OD/OADC)
Sent: Friday, May 25, 2018 10:47 AM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Cc: Sokler, Lynn (CDC/OD/OADC) ; Heldman, Amy B. (CDC/OD/OADC) ; Bonds, Michelle E. (CDC/OD/OADC) ; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) ; Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Galatas, Kate (CDC/OD/OADC)
Subject: FW: Note on the upcoming Vital Signs

See below. She edited the QA so want to be sure you all get that in your materials.

From: Daniel, Katherine Lyon (CDC/OD/OADC)
Sent: Friday, May 25, 2018 10:42 AM
To: Dee, Deborah L. (CDC/OCOO/HRO) <gdq7@cdc.gov>
Cc: Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>
Subject: Note on the upcoming Vital Signs

Hi Deborah,

You may be aware that the upcoming and long-planned Vital Signs covers the topic of suicide, with and without recognized mental health conditions. Given the unfortunate timing of the recent ruling, we are aware that reporters may mention Tim's death in connection with this research at CDC.

We want to make the family aware in advance that this is coming. We think it would be best done by phone, and some information to assist with that conversation below. Deb Stone (copied here) is the lead author of the Vital Signs MMWR, and has already at one point been in touch with the family regarding Tim (not on this VS). She has offered to be a resource if they want to talk through or have questions. At the bottom is a summary of two other upcoming publications, and our draft response if reporters ask questions linking the two (we will not discuss Tim's death other than to offer the statement below).

Can you let me know if you are willing and able to do this outreach? If not, who would you suggest?

Thank you.

KLD

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1. **Summary of the Vital Signs release:**

We want to make you aware of a long-planned CDC publication releasing soon, which we expect you will hear about in the news. CDC releases a *Vital Signs* report every month—this includes a *MMWR* article, a graphic fact sheet and website, a press release and media telebriefing, social media tools, and a Town Hall teleconference with states.

For the upcoming June Vital Signs (to be released June 7th), CDC researchers examined state-level trends in suicide rates from 1999-2016. In addition, they looked at the circumstances of suicide among people with and without known mental health conditions. Researchers in CDC's Division of Violence Prevention started this study more than six months ago.

We recognize that this is a painful topic at this time for your family and realize this timing is not ideal given the recent news. Please know Tim continues to be in the thoughts of the CDC family.

2. **Other upcoming and long-planned study releases we are aware of on this topic:**

- NCHS Quick Stats on suicide/homicide scheduled to publish in the same MMWR issue as the VS:
  Homicide and Suicide Rates for Teens Aged 15–19 Years — National Vital Statistics System, United States, 1999–2016 (Sally C. Curtin, scurtin@cdc.gov, 301-458-4142)
- The following forthcoming/tentative publication out of Chronic/DPH:
  Title: Suicide and life-threatening behavior
  Journal/Website/Publication: Archives of suicide research
  Date: June 4, 2018
  Tentative or Confirmed: Tentative
  Media Outreach/ Activities: None
  Rollout Plan Needed: No
  Talking Points/Q&A/Key Messages Needed: Yes
  Background: Limited US population-based studies used death certificate information to study suicide timing decades ago but did not analyze all calendar time periods by major demographic characteristics with multiple sources of death information. To study the spectrum of suicide timing systematically by age, sex, and race/ethnicity.
  Lead Author: Niu Tian
  Point of Contact: DeVonne Mitchell

3. **If CDC is asked by the press in the course of media interviews:**

Q: A CDC employee went missing in February and was later found deceased. His death was determined to be suicide. Is that why you're publishing this study now?

A: The CDC community continues to be deeply saddened and impacted by the death of Commander Cunningham. This study began many months before Commander Cunningham was reported missing. CDC has worked to prevent suicide for many years and suicide prevention is currently a priority area. We have a strong portfolio of research describing the increasing trends in suicide and rich data on circumstances contributing to suicide from the National Violent Death Reporting System. CDC also has a technical package geared towards states and communities that provides what works to prevent suicide based on the best available evidence.

With all of this information in hand and in the context of increasing national suicide rates, the present study was motivated to support states and our nation as we seek to meet the national goal of reducing annual suicide rates 20% by 2025.

June Vital Signs Summary

CDC releases a *Vital Signs* report every month—this includes a MMWR article, a graphic fact sheet and website, a press release and media telebriefing, social media tools, and a Town Hall teleconference with states.

For the upcoming June *Vital Signs* (to be released June 7th), CDC researchers examined state-level trends in suicide rates from 1999-2016. In addition, they looked at the circumstances of suicide among people with and without known mental health conditions. Researchers in CDC's Division of Violence Prevention started this study more than six months ago.

Some findings from this upcoming *Vital Signs* include:

State suicide rates vary widely

The report shows that suicide rates went up in nearly every state. Half of states had suicide rate increases of more than 30 percent.

Many factors contribute to suicide

In addition to mental health conditions, the report describes how other factors contribute to suicide risk, including relationship problems or loss, substance misuse; physical health problems; and job, money, legal or housing stress.

Wide range of prevention activities needed

We know that more action is needed to prevent suicide. The report recommends that states take a comprehensive public health approach to suicide prevention and address the range of factors contributing to suicide.

To help states with this important work, in 2017 CDC released a technical package on suicide prevention that describes strategies and approaches based on the best available evidence. We are hoping that the combination of the new report on trends and circumstance combined with the technical package will help inform states and communities as they make decisions about prevention activities and priorities.

Resources to share with the family if appropriate/requested:

To find out more about CDC's work in suicide prevention please visit our web site https://www.cdc.gov/violenceprevention/suicide/index.html or call [name?/Deb Stone?]

Losing a loved one to suicide is extremely difficult, but help is available:

Resources for Suicide Loss Survivors
http://www.suicidology.org/suicide-survivors/suicide-loss-survivors

Survivors of Suicide Support Group Directory
http://www.suicidology.org/suicide-survivors/sos-directory

National Suicide Prevention Lifeline (Number and Chat)
1-800-273-8255, https://suicidepreventionlifeline.org/chat/

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 2 May 2018 01:16:14 +0000
To: Deb Stone
Subject: FW: RE: Proposed talking points for SG at telebriefing

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From: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 1, 2018 2:58 PM
To: Bruce, Crystal (CDC/OPHPR/OD) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: RE: Proposed talking points for SG at telebriefing

Those look great to me.

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Tuesday, May 1, 2018 2:17 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Proposed talking points for SG at telebriefing

Hi all,

Based on today's meeting, here's the email and talking points I drafted to send up to the SG's office. Let me know if you think I'm on track with these, or not:

We had our Vital Signs workgroup meeting today and everyone thought it might be helpful if we proposed some talking points for Dr. Adams. I've pulled from the first part of the telebriefing script and here's what we propose:

- It's simply not acceptable that we are losing nearly 45,000 lives a year to suicide in this country, many of whom are military members or veterans.
- The tragedy of suicide demands a proactive and coordinated response, from all sectors in a community. We have been working with public and private partners to advance the National Strategy for Suicide Prevention.
- At the Federal level, we are tracking the problem of suicide and suicide attempts to better understand the trends and what groups at greatest risk.
- Today's report contains new information about rising suicide rates across the U.S. and highlights the range of factors contributing to suicide.
- The good news is there are opportunities to prevent suicide every day. Knowing the full range of factors contributing to suicide risk can help states and communities think more broadly about prevention opportunities.

Crystal Bruce, MPH
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Division of Violence Prevention, Health Communications Team
Office: 770-488-5651
Mobile: 470-249-3616
Cbruce2@cdc.gov
Off alternate Fridays

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 14 May 2018 15:40:50 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: FW: Suicide Vital Signs brief update and fact sheet
Attachments: edits to VS FS page 3 ds eb.docx, 18_292322-Simon_June_2018_Suicide_v6_05.10.18_ 5.00pm ds eb.pdf

4 of 4.

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 2:16 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Subject: RE: Suicide Vital Signs brief update and fact sheet

Added a couple minor edits

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 1:42 PM
To: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: RE: Suicide Vital Signs brief update and fact sheet

Offering my edits here for page 3 and for fact sheet (Tom, this is the same pdf I just sent you).
I'm really excited about the fact sheet! It looks great!
Deb

From: Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 1:08 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: RE: Suicide Vital Signs brief update and fact sheet

Hi everyone working on this great set of products,
I think this looks great! A couple of small style things to maybe look at are below.
Cory
Page 2 of PDF, I found the following wording a bit hard to follow "Crisis in the past upcoming two weeks". Is there a slash mark or some words needed between "past" and "upcoming"?
Page 4 of PDF, sticky note of edit under "everyone can". If going to include the Lifeline number here too, may want to include a "1" to read "1-800-....)
Word document with replacement graphic. The boxes that summarize the TP strategies use a variable format. Some capitalize all words, some capitalize only first word, and others have some sort of other mix.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 10:07 AM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Greenspan, Arlene (CDC/ONDIEH/NCIPC) <aig0@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: Suicide Vital Signs brief update and fact sheet

Hi everyone,

The pre-brief with Dr. Schuchat went very well. She is highly supportive and interested in the topic of suicide prevention. She and others in the room had helpful comments and suggestions related to the range of VS materials but their comments were fairly specific and will not result in substantive changes to our approach.

We are continuing to refine the fact sheet. I have attached a copy of the fact sheet pdf with embedded stickies to describe specific edits we are making. These reflect the changes we discussed with Dr. Schuchat and the VS office during and after the pre-brief. I'm also attaching a Word document that describes the changes that we are making to page 3. We are providing shortened text for the figure that was at the top of page 3. The VS graphics artists are going to modify the layout on this page but will use the text we provided. We are also adding the 5 steps to take when you are concerned about someone who may be suicidal. This was a good outcome from the discussion at the pre-brief.

The MMWR has completed review by OADS and their comments were quite minor. We addressed them this morning and Deb will be working closely with the MMWR editors early next week to finalize the MMWR.

Please let us know if you have any questions or suggestions.

-Tom

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 2, 2018 12:59 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Greenspan, Arlene (CDC/ONDIEH/NCIPC) <aig0@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: RE: Suicide Vital Signs Fact Sheet head's up

Hi everyone,

I just received the integrated version of the fact sheet with the new graphics and latest text. As I described below, I need to get changes back to the VS office tomorrow so that they can be integrated in the version that will go to Dr. Schuchat. If you have time to review it please send me changes by cob today and I'll integrate them. If not, there will still be time next week to make changes – so this is not your last chance. I just wanted to give you an opportunity to weigh in on anything problematic before it goes to Dr. Schuchat. Our team is reviewing it at the same time.

Thank you!
-Tom

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 1, 2018 6:04 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Greenspan, Arlene (CDC/ONDIEH/NCIPC) <aig0@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: Suicide Vital Signs Fact Sheet head's up

Hi everyone,
The fact sheet process has continued, including lots of wordsmithing types of editing but nothing too substantive. I'll share that Dr. Schuchat only had one change so far.
The VS graphic artist has been working on images separately from the wordsmithing and we have been reviewing drafts of the images.
We heard today that we should be receiving an integrated version with the text and graphics tomorrow and will need to turn it around by 10:00 a.m. on Thursday.
I wanted to give you a head's up in case you want to review it. I'll share it when it comes in tomorrow, but I won't have reviewed it yet and I know that they made changes since we last reviewed it so we'll probably have corrections/edits.
We have the pre-brief with Dr. Schuchat on Tuesday so the VS team wants to make our changes to the FS and provide it to her in advance of that meeting.
If you send changes by COB tomorrow we can make them in the version that will go to Dr. Schuchat. If you don't have time to review it tomorrow we should still be able to address your concerns next week so please still send them by Monday.
Thank you!
- Tom

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 4, 2018 4:38 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Greenspan, Arlene (CDC/ONDIEH/NCIPC) <aig0@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Subject: Suicide Vital Signs Fact Sheet

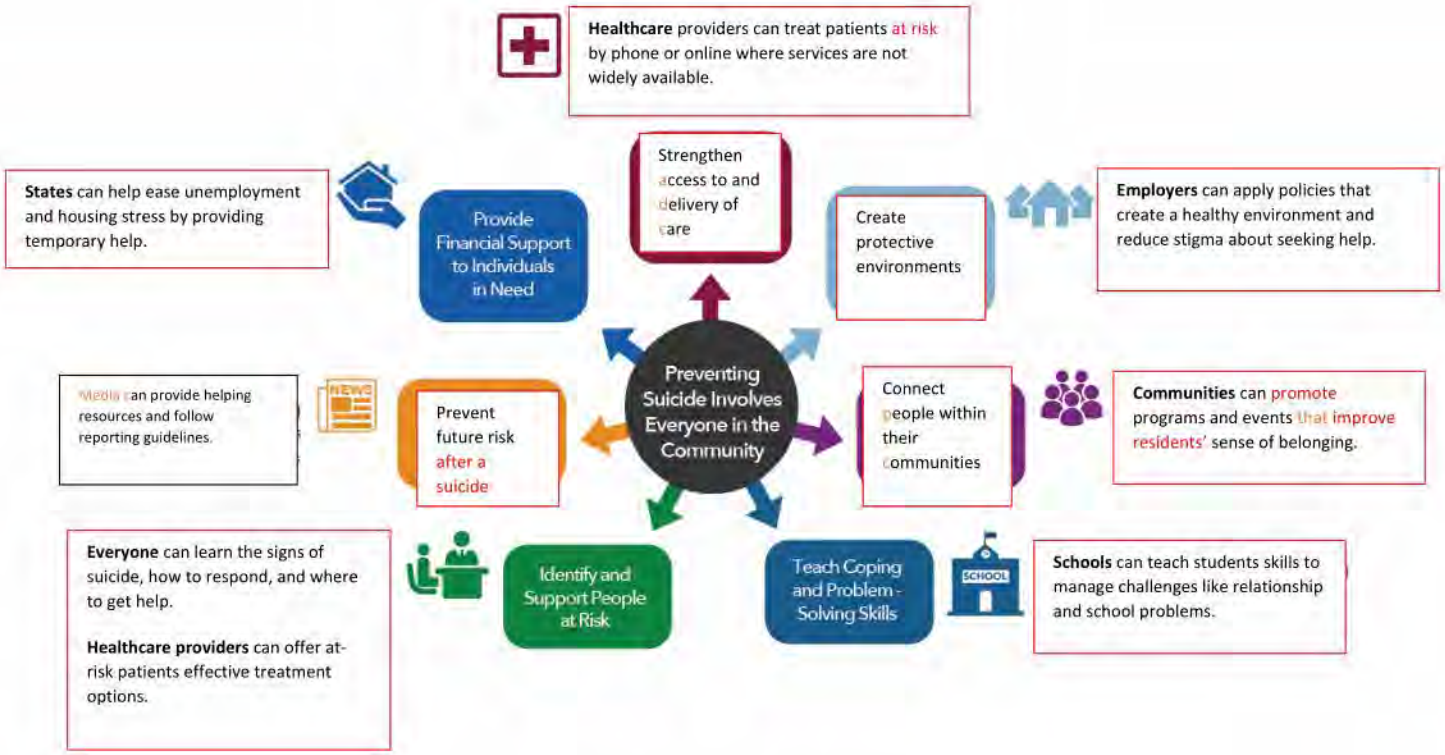
Hi everyone,
We had the roundtable with the VS office yesterday and it went well. We negotiated back and forth and spent a lot of time wordsmithing. For those who don't know, the round table lasts 3 hours and the focus is on getting the key messages into the VS fact sheet template. The fact sheet is 4 pages long but there are 14 pages of fact sheet rules and guidance (yes literally). Some things that might seem odd about the word choices, brevity, and headings in the draft attached are the result of this style guidance.

We and the VS team are feeling very good about where we are with this version. We think it really helps the reader to walk away knowing that suicide rates are increasing across states, that suicide is not only a mental health problem, and that there are a range of effective actions that can be taken to prevent suicide.

The team worked quickly to revise the fact sheet last night and today to incorporate the changes from the round table. We are going to continue to tweak this but we would like for you to review and please send us any requests for changes **by cob Friday**, if possible. We know that some people are on leave and won't be able to review this until Monday. We need to submit a revised version to the VS office on Tuesday. That version will be further edited by them, shared up the chain, and used to create better graphics. The graphics included now are placeholders. They have artists who will improve on these. We anticipate sharing the fact sheet with you again as it progresses but now is the time to let us know if there is anything substantial that you would like changed.

Thank you for your support on this Vital Signs!

-Tom and Deb



Note 1. Title shortened to 'WHAT CAN WE DO TO PREVENT SUICIDE?'

Note 2. We agreed to change the layout for the figures on page 3. Please use the text above to replace the original text. We are cutting about 25 words with these changes.

Note 3. There are two changes to the text of the warnings signs. Please use "Looking for a Way to Access Lethal Means" and "Talking or Posting About Wanting to Die" instead of what is there now. These changes are indicated in the pdf file too.

Note 4. The text for the steps to be listed on the right side under the warning signs should be:

5 Steps to help

- **Ask**
- **Keep them safe**
- **Be there**
- **Help them connect**
- **Follow up**

Find out why this can save a life by visiting: http://www.bethe1to.com/

Note 5. The source listed on the bottom right could be "Source: bethe1to.com" since they provide the warning signs and steps.

VS_v5_05/07/18_12:30 P.M.

#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 suicides in 2016.

↑30% Suicide rates increased more than 30% in half of US states since 1999.

50% More than half of people who died by suicide did not have a known mental health problem.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than just a mental health problem

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health problems are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health problem at the time of death. Other problems often contribute to suicide, such as relationship problems or loss, substance use disorders, physical health problems, and job, money, legal, or housing stress. Government, public health, healthcare, business, education, media and community organizations working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Connect people to others in their community so they don't feel alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



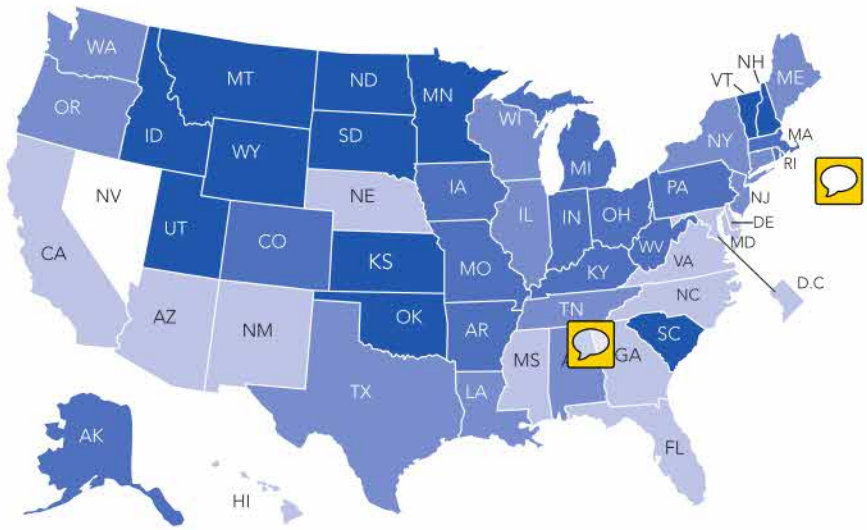
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.

Increase	38 - 58%
Increase	32 - 37%
Increase	19 - 29%
Increase	6 - 18%
Decrease	1%

SOURCE: *CDC's National Vital Statistics System.*

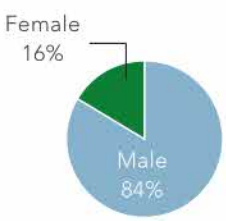


Differences exist among those with and without mental health problems.

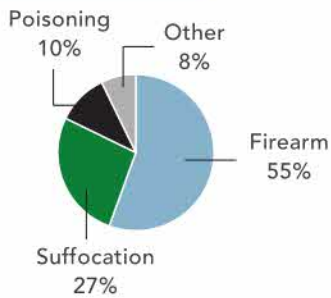
People without known mental health problems were more likely to be male and to die by firearm.

No known mental health problems

Sex

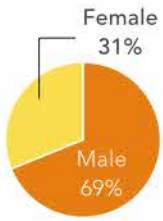


Method

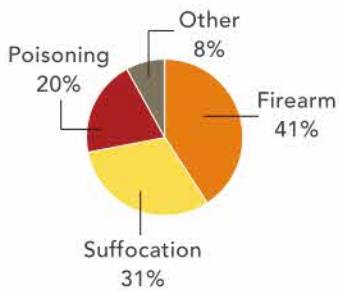


Known mental health problems

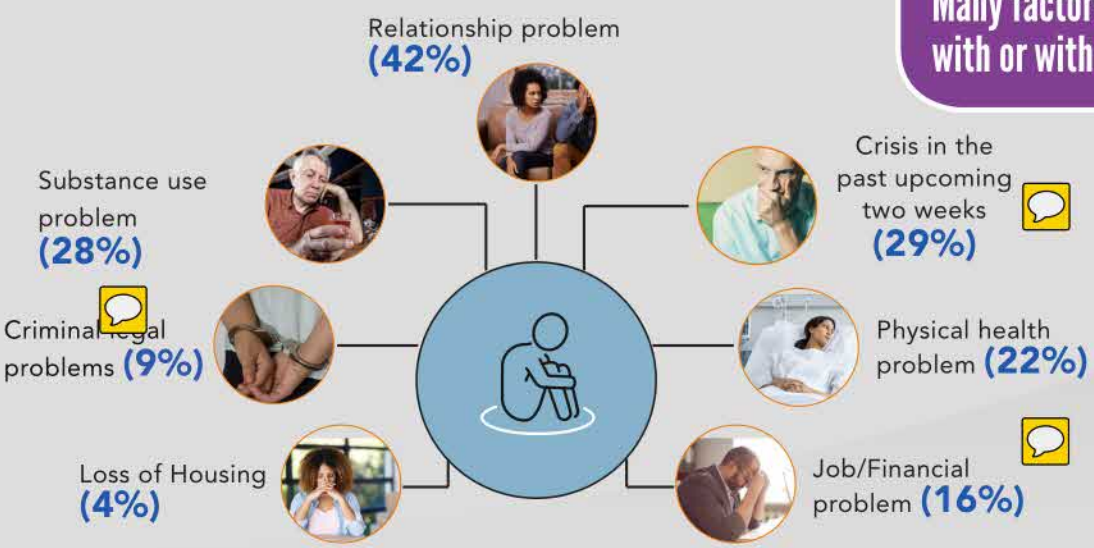
Sex



Method



Many factors contribute to suicide among those with or without mental health problems.



SOURCE: *CDC's National Violent Death Reporting System*

WHAT CAN STATES, COMMUNITIES, AND INDIVIDUALS DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc.

Healthcare providers can make services available by phone or online where treatments are not widely available.

States can help ease job loss and housing stress by providing temporary support.

Employers can put in place policies that create a healthy environment and reduce stigma about seeking help.

Media can describe helping resources and avoid headlines or details that increase risk.

Communities can offer activities that bring people together so people don't feel alone.

Everyone can learn the signs of suicide, how best to respond, and where to access help.

Healthcare providers can offer effective prevention services to those at risk.

Schools can teach skills that help young people manage challenges such as relationship and school problems.



SOURCE: CDC Vital Signs, June, 2018

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example see https://www.cdc.gov/violenceprevention/nvdrs/).
- Developing and evaluating suicide prevention strategies.
- Working with local, state, tribal, national, and other partners to provide guidance and distribute suicide prevention tools, (for example, see www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Connect people to others in their community so they don't feel alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

HEALTHCARE SYSTEMS CAN

- Provide high quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond effectively.
- Encourage employees to seek help when they need it. Provide referrals to mental health, substance use disorder, legal, or financial counseling services as needed.

EVERYONE CAN

- Reduce access to lethal means, such as medications and firearms, among people at risk.
- Learn the warning signs of suicide and the steps to help identify and connect people at risk to appropriate services. www.BeThe1To.com
- Contact the National Suicide Prevention Lifeline for help for themselves or others: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org/

The media can avoid increasing risk (e.g., with dramatic headlines, and explicit details) and encourage people to seek help using recommendations available at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018
CS292322-A

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 14 May 2018 15:40:20 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: FW: Suicide Vital Signs brief update and fact sheet
Attachments: 18_292322-Simon_June_2018_Suicide_v6_05.10.18_ 5.00pm ds.pdf

#3 of 4 – I added some comments below

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 1:24 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Suicide Vital Signs brief update and fact sheet

Hi Tom,

I made comments on the fact sheet (see attached). Including here as well. The biggest thing is the first comment but just throwing it out there, thinking about what the media could/may do with it. I know we can't control everything though.

1. Page 1: Regarding main headline. I think it's probably ok because we focus on prevention on the page as well but wondering if we could say "'suicide rates up' across the US? My only concern is that the media is going to glom onto the word rising and make it rising exponentially or who knows what else?

I don't know how to prevent that. Rising is relatively tame considering what we are seeing. Hopefully they will pay attention to the media recommendations.

2. Page 1: Re bullet about temporary help. Is there any way this could be misconstrued to mean 'provide temporary help for people in need,' more generally? I liked the mention of temporary financial assistance or help.

See how it looks in the new version

3. Page 2: It should be recent crisis in the past *or* upcoming two weeks.
4. Page 2: I think saying criminal-legal or criminal/legal might be easier than criminal legal which isn't really plain language.

I agree

5. Page 3: re 'looking for a way to access lethal means'—I think this sounds too passive (looking for a way to access..). It's often noted as 'securing lethal means.' Other options could be 'locating or looking for lethal means..'—i.e. Don't think we need the word access.

This is how the other warning signs word this.

6. Page 4: Is it possible to mention implementation somehwere? Samhsa supports implementation as does NIMH via funding and the header is broad to be federal gov't so i'm a little worried what we have only reflects CDC. We had implementing in here at one point but i think it wasn't plain lang enough and just got removed altogether.

I'm fine if this will fit.

7. Page 4: Is it possible to say train provers and graduate students? It may not work but really we need to start even earlier than training providers. Most MH care providers and PCPs don't have adequate training on suicide prevention. This is well accepted in the field (though I'm not sure we mention it in the technical package this way, can't recall)

If not in the TP then I would leave it out

Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 10:07 AM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Greenspan, Arlene

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Hi everyone,

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Please let us know if you have any questions or suggestions.

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Subject: RE: Suicide Vital Signs Fact Sheet head's up

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We and the VS team are feeling very good about where we are with this version. We think it really helps the reader to walk away knowing that suicide rates are increasing across states, that suicide is not only a mental health problem, and that there are a range of effective actions that can be taken to prevent suicide.

The team worked quickly to revise the fact sheet last night and today to incorporate the changes from the round table. We are going to continue to tweak this but we would like for you to review and please send us any requests for changes **by cob Friday**, if possible. We know that some people are on leave and won't be able to review this until Monday. We need to submit a revised version to the VS office on Tuesday. That version will be further edited by them, shared up the chain, and used to create better graphics. The graphics included now are placeholders. They have artists who will improve on these. We anticipate sharing the fact sheet with you again as it progresses but now is the time to let us know if there is anything substantial that you would like changed.
Thank you for your support on this Vital Signs!
-Tom and Deb

VS_v5_05/07/18_12:30 P.M.

#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 suicides in 2016.

↑30% Suicide rates increased more than 30% in half of US states since 1999.

50% More than half of people who died by suicide did not have a known mental health problem.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than just a mental health problem

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health problems are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health problem at the time of death. Other problems often contribute to suicide, such as relationship problems or loss, substance use disorders, physical health problems, and job, money, legal, or housing stress. Government, public health, healthcare, business, education, media and community organizations working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Connect people to others in their community so they don't feel alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



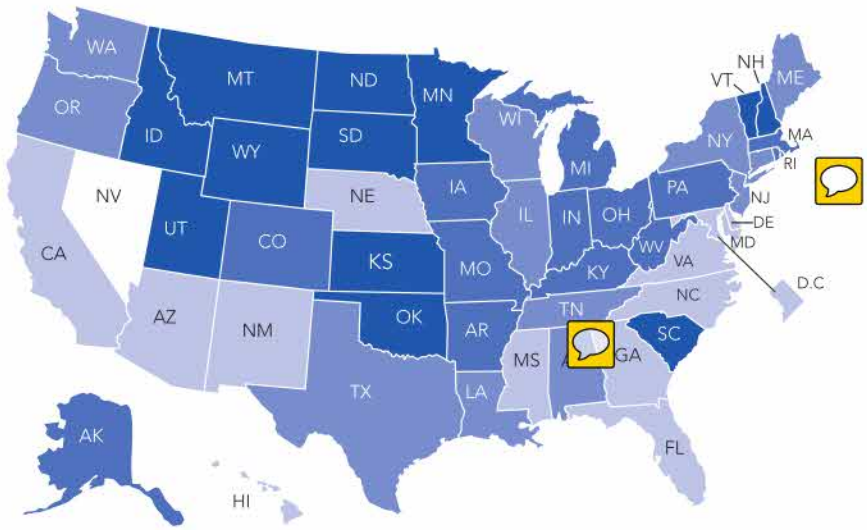
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.

Increase	38 - 58%
Increase	32 - 37%
Increase	19 - 29%
Increase	6 - 18%
Decrease	1%

SOURCE: *CDC's National Vital Statistics System.*

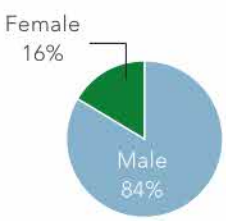


Differences exist among those with and without mental health problems.

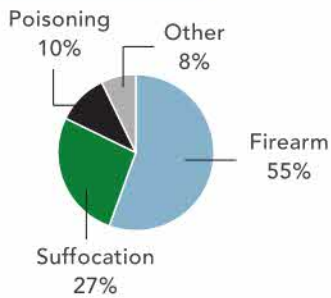
People without known mental health problems were more likely to be male and to die by firearm.

No known mental health problems

Sex

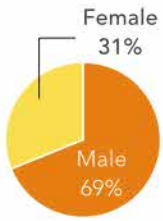


Method

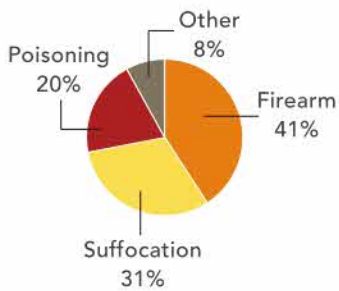


Known mental health problems

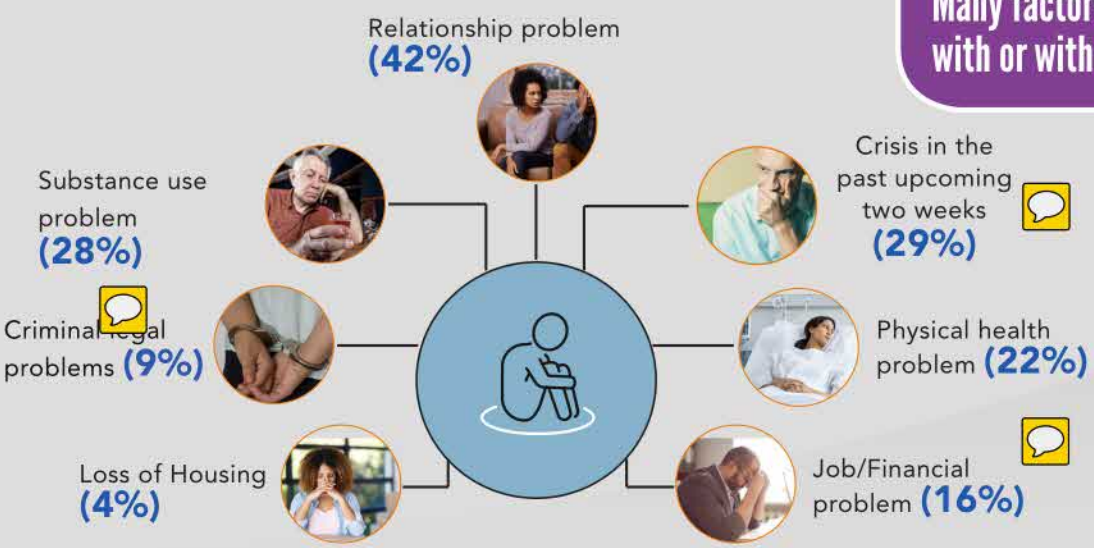
Sex



Method



Many factors contribute to suicide among those with or without mental health problems.



SOURCE: *CDC's National Violent Death Reporting System*

WHAT CAN STATES, COMMUNITIES, AND INDIVIDUALS DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc.

Healthcare providers can make services available by phone or online where treatments are not widely available.

States can help ease job loss and housing stress by providing temporary support.

Employers can put in place policies that create a healthy environment and reduce stigma about seeking help.

Media can describe helping resources and avoid headlines or details that increase risk.

Communities can offer activities that bring people together so people don't feel alone.

Everyone can learn the signs of suicide, how best to respond, and where to access help.

Healthcare providers can offer effective prevention services to those at risk.

Schools can teach skills that help young people manage challenges such as relationship and school problems.



SOURCE: CDC Vital Signs, June, 2018

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example see https://www.cdc.gov/violenceprevention/nvdrs/).
- Developing and evaluating suicide prevention strategies.
- Working with local, state, tribal, national, and other partners to provide guidance and distribute suicide prevention tools, (for example, see www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
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- Prevent future risk of suicide among those who have lost a loved one to suicide.

HEALTHCARE SYSTEMS CAN

- Provide high quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond effectively.
- Encourage employees to seek help when they need it. Provide referrals to mental health, substance use disorder, legal, or financial counseling services as needed.

EVERYONE CAN

- Reduce access to lethal means, such as medications and firearms, among people at risk.
- Learn the warning signs of suicide and the steps to help identify and connect people at risk to appropriate services. www.BeThe1To.com
- Contact the National Suicide Prevention Lifeline for help for themselves or others: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org/

The media can avoid increasing risk (e.g., with dramatic headlines, and explicit details) and encourage people to seek help using recommendations available at:
www.ReportingOnSuicide.org

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www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018
CS292322-A

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 14 May 2018 15:35:24 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: FW: Suicide Vital Signs brief update and fact sheet

#2 of 4

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Hi everyone working on this great set of products,
I think this looks great! A couple of small style things to maybe look at are below.
Cory
Page 2 of PDF, I found the following wording a bit hard to follow "Crisis in the past upcoming two weeks". Is there a slash mark or some words needed between "past" and "upcoming"?
Page 4 of PDF, sticky note of edit under "everyone can". If going to include the Lifeline number here too, may want to include a "1" to read "1-800-....)
Word document with replacement graphic. The boxes that summarize the TP strategies use a variable format. Some capitalize all words, some capitalize only first word, and others have some sort of other mix.

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We had the roundtable with the VS office yesterday and it went well. We negotiated back and forth and spent a lot of time wordsmithing. For those who don't know, the round table lasts 3 hours and the focus is on getting the key messages into the VS fact sheet template. The fact sheet is 4 pages long but there are 14 pages of fact sheet rules and guidance (yes literally). Some things that might seem odd about the word choices, brevity, and headings in the draft attached are the result of this style guidance.
We and the VS team are feeling very good about where we are with this version. We think it really helps the reader to walk away knowing that suicide rates are increasing across states, that suicide is not only a mental health problem, and that there are a range of effective actions that can be taken to prevent suicide.
The team worked quickly to revise the fact sheet last night and today to incorporate the changes from the round table. We are going to continue to tweak this but we would like for you to review and please send us any requests for changes **by cob Friday**, if possible. We know that some people are on leave and won't be able to review this until Monday. We need to submit a revised version to the VS office on Tuesday. That version will be further edited by them, shared up the chain, and used to create better graphics. The graphics included now are placeholders. They have artists who will improve on these. We anticipate sharing the fact sheet with you again as it progresses but now is the time to let us know if there is anything substantial that you would like changed.
Thank you for your support on this Vital Signs!
-Tom and Deb

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 13 May 2018 18:22:36 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: FW: Suicide Vital Signs deliverables calendar - releasing June 6
Attachments: June 2018 Deliverables calendar_21Nov2017.xlsx

Here you go!

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: Tuesday, November 21, 2017 5:06 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Cc: Mercy, James (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Sokler, Lynn (CDC/OD/OADC) ; Omisore, Shannon L. (CDC/OD/OADC) ; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Subject: Suicide Vital Signs deliverables calendar - releasing June 6

Hi Tom – Attached is a deliverables calendar for the suicide VS releasing June 5. We will go over this and the overall VS process and products at the kick-off meeting. Rich will be in touch to schedule this meeting.

Some key dates:

Draft MMWR and Fact Sheet (Word version) due for Roundtable (clearance <u>not</u> required at this stage): April 2
Roundtable: Aug 3 from 1:30-4:30 – please check schedules for availability for this 3 hour meeting
<u>CIO –cleared</u> MMWR and Fact Sheet due: April 10
CDC/OD review of MMWR and Fact Sheet (Word version): April 11 - 16
Fact Sheet (Word version) revisions and MMWR submission due: April 25
Other CIO-cleared pre-brief material (Press Release, Dear Colleague letter, Telebriefing script, Q&A, critical contacts) due: April 27
Fact sheet (graphic version), MMWR, and other pre-brief material due to CDC/OD –May 4
Pre-brief with Drs. Schuchat, MacKenzie, Lyon Daniel: week of May 7. CDC/OD will provide comments on all material at the pre-brief
FS(graphic version) and Press Release due to HHS/ASPA: May 18
Thanks,
Brandy

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Monday, November 13, 2017 3:28 PM
To: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Cc: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: Approval

Hi Brandy,

Thank you for this update. We would actually like to have the kickoff meeting as early as Rich and you are ready in January or early February. We will have a solid draft by then.

We look forward to seeing the calendar next week.

Thank you, Tom

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: Monday, November 13, 2017 2:29 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Cc: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC)

<zaf9@cdc.gov>
Subject: RE: Approval

Hi Tom – I am the Deputy Director for VS and develop the production calendars for each issue. I am working on calendars Feb thru June now. I won't have your exact deliverables dates until the next week or so, but typically a good **non-cleared** draft of the MMWR and Fact Sheet are due about 10 weeks before release. For your June 5 release that would be around the last week in March. We use those drafts in a Roundtable meeting where we edit the Fact Sheet for clearer messaging and language. A CIO-cleared MMWR and Fact Sheet are due about a week and half after the Roundtable (early April). Those versions will go to CDC/OD for review before submitting MMWR to ScholarOne and the Fact Sheet to the graphic artist. Although a fully cleared version of MMWR and Fact Sheet is not needed for the Roundtable, you'll want to start the clearance process well before the Roundtable since Center clearance will be required about a week and a half later for CDC/OD review.

Rich will be in touch to schedule an in-person kick-off meeting for some time in Feb. We will go over the deliverable dates in much more detail then.

Thanks,

Brandy

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Monday, November 13, 2017 8:45 AM
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Cc: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: Approval

Hi Rich,

Have you developed a master calendar yet? I would like to share it with our policy and communication colleagues.

Thank you, Tom

-Tom

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Monday, October 16, 2017 5:08 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: Approval

Tom,

Dr. F leaves this up to Dr. Schuchat. So it's definite, barring of course any unexpected events in D.C.

We'll get you the master schedule next week. Good thinking!

Rich

Sent from my iPhone

On Oct 16, 2017, at 16:11, Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov> wrote:

> Hi Rich,
> We wanted to thank you for this good news. I also wanted to ask about Dr. F's review.
> Does this green light mean that she approved this as a VS too?

Please do let us know when the deadline is for the first draft. We are working on analysis now. We anticipate receiving the 2016 Vital Stats data in December and should have the final results of that part of the paper in January.

Thank you, Tom

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Tuesday, October 10, 2017 11:22 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: Approval

Tom and Jim,

Dr. Schuchat liked your suicide prevention proposal. It's a green light to go ahead. Congratulations! And well-deserved, for sure.

We'll be in touch about next steps, but for now, please focus on the data analysis and MMWR write-up as you would for any other MMWR, but with the format restrictions we lay out in the MMWR/VS Instructions to Authors on-line at CDC.gov/MMWR. These indicate the abstract length (250 words), text length (1800-2000 words), number of figures or tables (4), and references (15). The Key Points should be written in plain language; we can help revise that part into plain language along w your Comms person. I don't have a deadline date for the MMWR first draft but you are at least several months from that time. Brandy can help you with that and other dates.

Let us know your questions and issues as they come up. No question is too small!

Best,

Rich

Sent from my iPhone

June 5, 2018
Suicide

Abbreviated Timelines of Deliverables, 11/21/2017

Step	Deliverable	Begin at 08:00 A.M.	End by COB	Workdays	Deliver to	Comments
Analysis, Direction-setting, and MMWR Prep						
1	(1) DIRECTION AND ANALYSIS: Initial Meeting		TBD			
2	OD Planning Document/SOHCO/One Thing		DONE		RS, LS	
3	CDC/OD review of ODPD/SOHCO/One Thing		DONE			
4	Program (PGM) respond in writing to questions from CDC/OD		DONE		RS	
5	(2) MMWR: MMWR draft(non-cleared)written and sent to VS team to help guide FS development during the RT discussion only		2-Apr		RS	
6	Pre-submission CIO-cleared MMWR due to VS team		10-Apr			
7	CDC/OD(Dir, Principal Depuy Dir, OADS, OADC); CSELS (Rasmussen, Kent)review pre-submission CIO cleared and cross-cleared MMWR	11-Apr	16-Apr	4	RS	MMWR and FS will be sent to CDC/OD at the same time.
8	PGM revises, cross-clears and submits MMWR to Editors	17-Apr	25-Apr	7	MMWR Submission System, RS, LS	Max 1800 word text 250 word abstract 15 references Submit to MMWR by noon Please send VS team a comment/response matrix on how you addressed comments from Drs. Schuchat, Mac Kenzie, and Lyon-Daniel. Matrix only needed for comments from these 3 reviewers
9	MMWR edited and produced	26-Apr	9-May	10	MMWR Editors and Reviewers, PGM, RS	
10	SCIENCE CLIPS: PGM provides citations for Science Clips		21-May		RS	
11	Rich reviews citations and sends to OD/OADS and CDC librarian		22-May		Bill Thomas John Iskander Gail Bang	
Fact Sheet (Word and Graphics Versions)						
12	(3) FACT SHEET: Send FS (non-cleared) in Word (W) format to VS team		2-Apr		LS, RS	
13	Roundtable	3-April 1:30-4:30			LS, RS	
14	CIO-cleared post-RT FS(W) due to VS team	4-Apr	10-Apr	5	LS, RS	
15	CDC/OD (Dir, Principal Depuy Dir, OADS, OADC,PARP, PPEO); CSELS (Rasmussen, Kent, Royster, Martin); CDCW review CIO-cleared FS(W)	11-Apr	16-Apr	4		

16	**Pgm revises FS(W) from CDC/OD, CSELS, CDCW comments and submits revised FS(W) to VS team**	17-Apr	25-Apr	7	RS,LS	Please send VS team a comment/response matrix on how you addressed comments from Drs. Schuchat, Mac Kenzie, and Lyon-Daniel. Matrix only needed for comments from these 3 reviewers
17	**Complete internal graphic development**	26-Apr	4-May	7	LS	
18	**CDC/OD (Principal Depuy Dir, OADS, OADC); CSELS (Kent); CDCW review full-color FS(G)**	4-May	Pre-brief with Principal Deputy Director, ADS, ADC (week of 5-Feb)		RS, LS	Principal Deputy Director, ADS, ADC will provide comments on FS, PR, telebriefing script,Q&A at the pre-brief Kent, CDCW will receive courtesy copies
19	**Work days: Final edits to FS(G)**	Pre-brief with Principal Deputy Director, ADS, ADC	17-May			
20	**HHS/ASPA review and clear full-color FS(G)**	18-May	24-May	5	LS to NMB to HHS/ASPA	Send FS with Press Release through NMB
21	**CDC Locks down full-color graphic FS(G)**		24-May		LS	at 5:00pm
22	**CDC final publication preparation (English and Spanish)**	25-May	4-Jun	6	LS	LS to send English FS to Shannon Omisore for Spanish translation Holiday 28-May
Other Materials Produced						
23	**Medical Outreach Program call**		while FS is being reviewed by OD		Brandy Peaker	Program to discuss with VS potential outreach strategies for clinicians
24	**(5) TOWN HALL MEETING PREP: PGM finds 2 local demo pgms for Town Hall Mtg**		8-May		OSTLTS: Chelsea Payne, Tonya Joyner	PGM works independently with OSTLTS for this
25	**(6) PRESS RELEASE (PR) and ONE GRAPHIC: Lynn receives draft, edits it, and sends revision back to PGM**		27-Apr		PGM	
26	**Pgm revises PR**	30-Apr	4-May	5	LS, DNEM	
27	**OADC reviews PR**	7-May	11-May	5		
28	**Pgm revises PR from OADC review**	14-May	17-May	4		
29	**HHS/ASPA receives and clears PR**	18-May	24-May	5	LS	
30	**PGM OKs ASPA changes to social media materials and PR**		25-May	1	LS	
31	**Lynn, graphics, and PGM to work on "one graphic" to go with PR**	18-May	24-May	5	LS	
32	**(7) DEAR COLLEAGUE LETTER: PGM writes/clears/submits**		27-Apr		LS	CD sends to MLS for Spanish translation
33	**(8) TELEBRIEFING SCRIPT and Q&A PGM writes/clears/submits**		27-Apr		LS	SO sends English script to Belsie Gonzalez for Spanish talking points

34	**(9) CRITICAL CONTACTS and EMAIL PGM writes/clears/submits**		27-Apr		RS/LS	
Final Activities						
35	**(12) SOCIAL and ELECTRONIC MEDIA: Meet with Kamelya Hinson and PGM to go over Social and Electronic Media**		24-Apr		LS, DNEM,PGM	6 weeks prior to release; OADC to provide PGM with a social media template
36	**PGM to provide content to Kamelya Hinson; PGM works with LaKia Bryant to provide content on Digital Press Kit**		8-May		PGM, Kamelya Hinson, Arezoo Risman	4 weeks prior to release; PGM to work directly with OADC on social and electronic media. SO sends to MLS for Spanish translation
37	**(13) VS WEBSITE BUILT: PGM provides its links and alt text to LS**	25-May	31-May	4	LS, DNEM,PGM	Spanish Website also built Holiday 28-May
38	**Rich creates CDC Announcement**		29-May		Rhonda Smith	CDC Announcement released at 2pm on 6-Mar
39	**(14) PRE-BRIEFING: LS sends latest MMWR proof, FS/Graphics version, PR, Telebriefing Script, Q&A, Critical Contacts List and draft email**		4-May		LS	PGM to send all requested material by 10AM
40	**Pre-brief with Principal Deputy Director, ADS, ADC**		week of 7-May		In-person (unless traveling)	Bldg 21, 12th floor DIV: Leadership, Comm, Policy, Science SMEs Call in number provided
41	**Pre-brief with CDC Director**		week of 21-May		In-person (unless traveling)	Dir Conf Rm, Bldg 21, 12th floor DIV: Leadership, Comm, Policy, Science SMEs Call in number provided
42	**(15) NOTIFICATIONS: NPHIC call (PGM attends)**		31-May		LS, DNEM, PGM	
43	**Internal--Final materials sent to leadership and distributors**		4-Jun			Done by LS
44	**External - CDC Director sends out email to "Critical Contacts"**		5-Jun			Email should include that information is embargoed until 1pm on release date
45	**External (cont) - PGM sends email to "Critical Contacts" not otherwise contacted by CDC/OD**		5-Jun			Email should include that information is embargoed until 1pm on release date
46	**External (cont)--PGM and OSTLTS notify all other partners of impending release**		5-Jun			BRANCH: SME, Chief, Comm, Policy; Embargo in place until 1 pm
47	**(16) RELEASE Press receives materials under embargo**		5-Jun		RS, LS, DNEM	Embargo in place until 1pm
48	**CDC Director conducts telebriefing Materials released to public at 1pm**		5-Jun		TRF, LS, RS, OADC, PGM	Immediate Pre-brief 11:40; Telebrief at NOON, Dir Conf Rm, Bldg 21, 12th floor DIV: Director, Comm, Policy BRANCH: Chief, SME, Comm, Policy
49	**(17) MEDIA METRICS COLLECTED 24-hour media report due**		6-Jun		LS, DNEM	
50	**30-day Media report due**		30 days after release		LS, DNEM	
51	**(18) OSTLTS TOWN HALL PGM participates**		12-Jun		OSTLTS	SME presents overview

From: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Sent: 3 Jan 2018 15:36:10 -0500
To: Bartholow, Brad (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Girod, Candace (CDC/ONDIEH/NCIPC)
Subject: FW: Technical Package Citation Scan
Attachments: TP Citations across the internet.xlsx

Sharing great news from Candace!!

From: Girod, Candace (CDC/ONDIEH/NCIPC)
Sent: Wednesday, January 3, 2018 3:20 PM
To: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Cc: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: Technical Package Citation Scan

Hey Jeff and Linda,
I'm attaching a spreadsheet with any websites that mention the technical packages. This doesn't include any journal articles.
One interesting takeaway was that of the 208 websites I found, almost 70 cited the suicide technical package.
I will find a good way to summarize all of my findings in the next TP update.
Best,
Candace

State	Organization	Type of website	Fed Support	Date	Context	TP	Link/PDF	URL
National	Suicide Prevention Resource Center	advocacy org/community of practice/res	SAMHSA	3/3/2017	Short blurb in a week	Suicide	link	http://www.sprc.org/news/preventing-suicide-technical-package-policy-programs-practices
New Zeal	New Zealand Family Violence Clearinghouse	Resource Clearinghouse	no	5/29/2017	Longer blog post defi	All	link	https://www.nzfvc.org.nz/news/new-technical-package-preventing-intimate-partner-violence-pdf
National	National Center on Safe Supportive Learning En	National Government Website	DOE/AIR		resources section bli	Suicide	link	https://safesupportivelearning.ed.gov/resources/promoting-suicide-prevention-package-policy-programs-and-practices-0
National	Youth.Gov	National Government Website	yes	2/23/2017	resources section bli	Suicide	link	https://youth.gov/federal-links/resource-preventing-suicide-technical-package-policy-programs-and-practices
National	The national center for campus public safety	Resource Clearinghouse	DOJ		resources section bli	Suicide	link	https://www.nccpsafety.org/resources/library/preventing-suicide-a-technical-package-of-policy-programs-and-practices/
National	The national center for campus public safety	Resource Clearinghouse	DOJ		resources section bli	IPV	link	https://www.nccpsafety.org/resources/library/recommendations-technical-package-for-the-prevention-of-youth-violence-and/
National	The national center for campus public safety	Resource Clearinghouse	DOJ		resources section bli	SV	link	https://www.nccpsafety.org/resources/library/stop-sv-a-technical-package-to-prevent-sexual-violence/
National	The national center for campus public safety	Resource Clearinghouse	DOJ		resources section bli	IPV	link	https://www.nccpsafety.org/resources/library/preventing-intimate-partner-violence-across-the-lifespan-a-technical-package
National	National Network of Libraries of Medicine	Resource Clearinghouse	NIH	9/14/2017	resources section bli	All	link	https://news.nnlm.gov/files/2017/09/cdc-technical-package-for-violence-prevention/
National	Stopbullying.gov	National Government Website	HHS	9/14/2017	blog post by CDC tod	Suicide	link	https://www.stopbullying.gov/blog/2017/09/14/new-cdc-resource-can-help-states-and-communities-prevent-suicide-among-youth.html
National	Safe States	community of practice	CDC	2/24/2017	short blurb in partne	Suicide	link	http://www.safestates.org/news/733579/Technical-Package-Helps-States-and-Communities-Prioritize-Strategies-to-Prevent-Suicide.htm
CT	University of Connecticut Humphrey Clinic for S	university service provider	no	8/18/2017	resources section bli	Suicide	link	https://humphreyclinic.uconn.edu/2017/08/18/suicide-prevention-information/
National	American Foundation for Suicide Prevention	advocacy org/community of practice/res	no	march/apri	webinar announcem	Suicide	link	https://afsp.org/prevention-community-based-approaches-suicide-prevention-new-resources-future-directions-webinar/
National	Action Alliance for suicide prevention	advocacy org/community of practice/res	SAMHSA	3/31/2017	webinar announcem	Suicide	link	https://actionallianceforsuicideprevention.org/webinar-community-based-approaches-suicide-prevention-new-resources-and-future-directions
National	The Nation's Health/APHA	professional development	no	Jul-17	article in monthly ne	All	link	http://thenationshealth.aphapublications.org/content/47/5/7.full
CT	CT Suicide Advisory Board	advocacy org	no		resources section	Suicide	link	https://www.preventsuicidect.org/resources/online-training-colleges/
SD	Yankton Rural Area Health Education Center	service provider	HRSA	2/17/2017	HRSA webinar announ	Suicide	no link	http://yanktonrwjahec.org/?p=a&event_id=2436
MT	Montana DPHHS	State Government Website	no		resources section	Suicide	link	https://dphhs.mt.gov/suicideprevention/data/suicideresources
National	Future of Personal Health	news aggregator	no		article about suicide	Suicide	no link	http://www.futureofpersonalhealth.com/adolescent/care-for-veterans-messy-dressing-the-problems-of-opioid-abuse
VT	Vermont Suicide Prevention Center	technical assistance	no		resources section bli	Suicide	link	https://vspc.org/listings/
CO	Colorado Health Service Corps	professional development	no	4/13/2017	blog post	Suicide	link	https://www.linkedin.com/pulse/new-suicide-prevention-tool-help-guide-communities-service-corps
National	US HHS Office of Minority Health	National Government Website	HHS	8/30/2017	blurb in newsletter	Suicide	link	https://content.govdelivery.com/accounts/USOPHSOMH/bulletins/1838825
NY	New York State School Social Workers' Associat	professional development	no		resources section bli	Suicide	link	https://nysswa.org/crisis-response/suicide-prevention-intervention/
UT	Utah Valley University	university research center	no		slides in a presentati	Suicide	link	https://www.uvu.edu/childabuse/docs/gail_gray_aasahl_final_visit.pdf
National	American Psychological Association	professional development	no		resources section	Suicide	link	https://www.apa.org/advocacy/suicide/prevention/index.aspx
National	Husch Blackwell (legal consultants)	health-focused business	no	10/30/2017	blog post	Suicide	link	https://www.4.ciheglancights.com/2017/10/cdc-releases-guidance-schools-prevent-suicide/
CO	Colorado Child Fatality Prevention	community of practice	no	3/2/2017	blog post	Suicide	link	https://www.coloradochildfatalityprevention.com/2017/03/presenting-suicide-technical-package-of.html
National	MD Mag	professional development	no	10/18/2017	blog post about suici	Suicide	link	http://www.mdmag.com/medical-news/cdc-releases-new-suicide-rates-strategy-reporting-brief
NJ	Monmouth Cares Inc (resource org for NJ count	service provider	no		blurb in news section	Suicide	link	https://www.monmouthcarescenter.org/news-events/news/preventing-teen-suicide-when-the-worst-happens
CA	Fresno Cares (county suicide prevention org)	service provider	no		resources section	Suicide	link	https://www.fresnocares.org/national-strategy-for-suicide-prevention/
ID	Boise State University	university research center	no		references section	Suicide	link	https://radar.boisestate.edu/child-review/helpful-information/references/
LA	Families helping Families	service provider	no		resources section bli	Suicide	link	https://lfhjefferson.org/building
National	Compassion and Choices	advocacy org	no	9/27/2017	article supporting pa	Suicide	link	https://www.compassionandchoices.org/supporters-of-medical-aid-in-dying-oppose-new-house-resolution-opposing-it/
NY	New York State Department of Health	State Government Website	no		resource section	Suicide	link	https://www.health.ny.gov/statistics/prevention/injury_prevention/index/
MI	Saginaw Suicide Prevention	service provider	no		resource section	Suicide	link	http://www.saginawsuicidepreventionline.org/resources.html
NY	The Jed Foundation	funder	no		resource section	Suicide	link	https://www.jedfoundation.org/mental-health-resource-center/recommended-resources/
NM	New Mexico Department of Health	State Government Website	no	11/3/2017	Suicide Fact Sheet	Suicide	link	https://ibis2.nmdoh.state.nm.us/publications/importance_FactSheet.html
NM	New Mexico Department of Health	State Government Website	no	11/1/2017	Suicide report for ea	Suicide	link	https://ibis.health.state.nm.us/community/highlightprofile/SuicDeath.CityTown/SuicDeath/17.html
National	National Institute of Mental Health	Federal Government Website	NIH		Suicide Fact Sheet	Suicide	link	https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml
CA	City of Palo Alto Project Safety Net	service provider	no		resource section	Suicide	link	http://www.projectsafenet.com/resources/
National	National Association of State Mental Health Pro	community of practice	no	4/7/2017	article in monthly ne	Suicide	link	https://www.nasmhpd.org/sites/default/files/April-7-2017-NASMHPD_Weekly_Update.pdf
CO	Colorado Springs Health Foundation	funder	no		resource section	Suicide	link	http://csfh.net/resources/
National	NCSL	advocacy org/community of practice/res	no	8/28/2017	longer Blog Post	Suicide	link	http://www.ncsl.org/blog/2017/08/23/combating-rising-suicide-rates-only-scientific-research.aspx
National	National Center on Domestic and Sexual Violen	advocacy org/community of practice/res	no		resource section	Suicide	link	http://www.ncdsv.org/publications_Suicide.html
KS	Kansas Department of Health and Environment	State Government Website	no	Sep-17	blurb in monthly new	Suicide	link	http://www.kdheks.gov/cshp/hk_Connections/Connect09-17.pdf
UT	Mountainlands Community Health Center	service provider	FQHC		resource section	Suicide	link	http://mountainlandchc.org/blog/best-resources/aftermath-of-suicide-mental-health-info-from-chc/
National	Thunderclap	business	CDC		short blurb	Suicide	link	https://www.thunderclap.it/projects/59738-help-stop-suicide-risk-before
MI	Michigan Association of Community mental hea	community of practice	no	4/21/2017	short blurb in weekly	Suicide	link	https://www.mnaresults.org/sites/default/files/attachments/files/042117.pdf
IL	Prevention First (substance abuse prevention n	technical assistance	no		resource section	Suicide	link	https://www.preventionfirst.org/stream-Clearinghouse/Suicide-and-Suicide-Prevention/
National	Cision PR Newswire (healthcare practice news	news aggregator	no	9/27/2017	article about military	Suicide	link	http://www.prnewswire.com/news-releases/supporters-of-medical-aid-in-dying-oppose-new-house-resolution-opposing-it-300527001.html
??	Betty Clung's (public health consultant) Websit	personal blog	no		resource section	Suicide	link	http://www.bettyclung.net/Pnotal.htm
National	Zero Attempts.Org	advocacy org	no	3/30/2017	resource section	Suicide	link	https://www.zeroattempts.org/services.html
MI	No Bullying, Yes Empowered Program at Boyne	health-focused business	no	9/18/2017	facebook post, links	Suicide	link	https://www.facebook.com/anxiety/
CO	Colorado Department of Public Health and Envi	State Government Website	no		short blurb in annual	Suicide	link	https://www.colorado.gov/pacific/sites/default/files/PW_YSIP_OSP-2016-DV(7)_Updated-Report.pdf
National	Society for academic emergency medicine	professional development	no	septembe	mentioned in Beh He	Suicide	link	https://saem.org/docs/default-source/publications/saem_pulse_sept-oct_17
FL	Florida Council for Community Mental Health	advocacy org	no	4/7/2017	short blurb	Suicide	link	http://fccmh.org/news/index.asp
National	Kidsdata.org	Data Resource	no		references section	Suicide	link	http://www.kidsdata.org/topic/33/youth-suicide-and-self-inflicted-injury/summary
National	Social Work Career	professional development	no	Apr-17	ad for the April Webi	Suicide	link	https://www.socialwork.career/2017/04/free-mental-health-webinars.html
National	CAMS-Care: Preventing Suicide	technical assistance	no		citing TP as evidence	Suicide	link	https://cams-care.com/faq/
VT	Vermont Suicide Prevention Coalition	advocacy org	no		in the agenda for the	Suicide	no link	https://www.preventingvt.com/s/vermont-suicide-prevention-coalition-meeting-by-invitation-only-tickets-132405318398
Brazil	LinkMedicus.com	professional development	no	8/31/2017	supporting documen	Suicide	link	https://linkmedicus.com/specialties/psychiatry/
CA	Santa Clara County department of health	county government website	no		resource section	Suicide	link	https://www.ccgov.org/sites/bhd/Services/59/Documents/2017/cdc-suicidetechnical-pkg-2017.pdf
National	Cornell University Self Injury and Recovery Res	university research center	no		resource section	Suicide	link	http://www.selfinjury.bctr.cornell.edu/perch/resources/suicide-technicalpackage.pdf
NY	suicide prevention center of new york	non-profit	no	4/10/2017	resource section	Suicide	link	http://www.preventnys.org/index.cgi/459/suicides
VA	Virginia Department of Behavioral health & dev	technical assistance	no	3/9/2017	news section	Suicide	link	https://www.virginiapreventionworks.org/cdc-releases-preventing-suicide-a-technical-package-of-policy-programs-and-practices/
National	Safe States	community of practice	no		compendium of inju	Suicide	link	https://www.safestates.org/page/IPI_Suicide_pg12
CT	Southbury & Middlebury Acting Responsibly To	advocacy org	no		short blurb	Suicide	link	https://www.smarthc.org/s-suicide_prevention1.aspx
National	Ac Health (mental health professional newslett	professional development	no	Sep-17	short blurb	Suicide	link	https://allhealth.com/suicide-resources.fpnl/
National	Independent Physicians Network	professional development	no	9/10/2017	references section	Suicide	link	http://www.ipnhealth.org/prevent-ring-suicide/
New Zeal	Waiwes (Waitakere Anti-Violence Essential Serv	service provider	no	5/25/2017	article about IPV tact	All	link	http://www.waiwes.org.nz/blog/new-technical-package-on-preventing-intimate-partner-violence-from-cdc/
South Afr	The South African Depression and Anxiety Grou	Resource Clearinghouse	no		repost of Independe	Suicide	link	http://www.sadag.org/index.php?option=com_content&view=article&id=2454:preventing-suicide-cdc-releases&catid=147&Itemid=133
??	Hobbab Local	news aggregator	no	8/10/2017	repost of Independe	Suicide	link	http://hobbabmaster.com/preventing-suicide/
National	PreventConnect	technical assistance	CDC	5/12/2017	webinar announcem	SV	link	http://www.preventconnect.org/2016/05/stop-sv-a-technical-package-to-prevent-sexual-violence/
MN	Battered Women's Justice Projet	Resource Clearinghouse	HHS	May-16	short blurb in resour	SV	link	http://www.bwjp.org/resource-center/resource-results/cdc-cs-prevention-technical-package.html
National	Youtube/CALCASA	advocacy org/community of practice/res	CDC	6/1/2016	video of a webinar o	SV	no link	https://www.youtube.com/watch?v=HdP4ZKTPIYg
National	National Sexual Violence Resource Center	advocacy org/community of practice/res	CDC		resource section	SV	link	https://www.nsvrc.org/sites-0
CA	CALCASA	advocacy org/community of practice/res	no	4/26/2017	blog post	sv	link	https://www.calcasa.org/2016/04/stop-sv-cdc-on-preventing-sexual-violence/
VA	Community Solutions to Sexual and Domestic V	Resource Clearinghouse	no		resource section	SV	link	https://www.communitysolutionsva.org/index.php/resources/item/stop-sv-a-technical-package-to-prevent-sexual-violence
National	Prevent IPV	community of practice	no		resource section	SV	link	https://preventipv.org/mutant/stop-sv-technical-package-prevent-sexual-violence
National	National Center on Safe Supportive Learning En	National Government Website	DOE/AIR		short blurb in resour	Sv	link	https://safesupportivelearning.ed.gov/resources/stop-sv-technical-package-prevent-sexual-violence
National	VAWnet	Resource Clearinghouse	no		resource section	SV	link	https://vawnet.org/material/stop-sv-technical-package-prevent-sexual-violence
OH	Helpline	service provider	no	4/11/2017	Press release repost	SV	link	http://fieldcreekmhc.org/cdc-stop-sv-a-technical-package-for-prevention-sexual-violence/
National	National Network of Libraries of Medicine	Resource Clearinghouse	HHS	9/14/2017	blog post	sv	link	https://news.nnlm.gov/files/2017/09/stop-technical-packages-for-violence-prevention/
National	Safe States	community of practice	CDC		resources section	sv	link	http://www.safestates.org/page/IPI_SexualViol_pg15
National	national sexual violence resource center	advocacy org/community of practice/res	sdc		resources section	sv	link	https://www.nsvrc.org/publications/taxonomy/term/25?page=1
WI	Wisconsin Coalition Against Sexual Assault	advocacy org/community of practice/res	no		article about PH appr	sv	link	http://www.wcasa.org/page/Prevention-Frameworks.php
National	ASTHO	community of practice	no?	4/13/2017	article about PH appr	sv	link	http://www.astho.org/StatePublicHealth/An-Ounce-of-Prevention-for-Sexual-Violence/4-13-17/
UT	Safe Harbor Crisis Center	service provider	no		cited in an ad for bys	sv	link	http://safeharborinc.org/CARES.htm
CA	Project.IE	technical assistance	no		about page	sv	no link	https://www.projectie.education/impact/
NH	Dartmouth Student Wellness Center	university service provider	no		resources section	sv	no link	https://www.dartmouth.edu/~healthed/violence_prevention/vp_research.html
WA	Washington State Department of Health	State Government Website	no		article about their RF	sv	no link	http://www.doh.wa.gov/Portals/1/Documents/2400/DOH-RPC-F3.pdf
National	Violence Epidemic	advocacy org	no		resources section	sv	link	http://violenceepidemic.com/success/
NY	New York State Department of Health	State Government Website	no		resources section	sv	link	https://www.health.ny.gov/prevention/sexual_violence/resources_program.htm
National	SAFE ta.org (technical assistance for sexual vio	professional development	no		resources section	sv	link	https://www.safeta.org/page/Prevention
IL	Illinois School and Campus Safety Resource Cer	Resource Clearinghouse	no		resources section	sv	link	https://www.illinoisatlantic.org/index.php/higher-ed-resources/interpersonal-violence-highered/sexual-violence-highered
National	Culture of Respect (part of Student Affairs Adm	community of practice	no		resources section	sv	link	https://cultureofrespect.org/program/envision-behind-door-acknowledge-act-ease-sexual-assault-resistance/
NM	New Mexico Department of Health	State Government Website	no		infographic	sv	no link	https://nmhealth.org/publication/view/marketing/4286/
WI	Milwaukee Board of School Directors	State Government Website	no		references section	sv	no link	http://esp.milwaukee.k12.wi.us/attachments/dreads202_4053-4a9d-88f6-0f8be8f230b8.pdf
IN	Indiana Coalition to End Sexual Assault	advocacy org	no		resources section	sv	link	http://endsexualv.iu.edu/resources/prevention/
MN	Minnesota Department of Health	State Government Website	no		article about sexual h	sv	link	http://www.health.state.mn.us/topics/sexualhealth/sexualhealth.pdf
National	Department of Justice	National Government Website	DOJ		resources section	sv	link	https://www.justice.gov/ovw/protecting-students-sexual-assault
National	Safety UI	Resource Clearinghouse	no		resources section	sv	link	https://www.safetyui.org/citations/index.php?search=&conditions_searched=&citation%5B%5D=&report_257_20
BC	family Dynamix (Canada Based family resource	service provider	no		blog post	sv	link	http://familydynamix.ca/talking-points/
MD	Maryland Department of Health	State Government Website	no		IPV prevention articl	sv	no link	https://phpa.health.maryland.gov/dvsa/pdp/Shared%20Documents/IPP-RESOURCE/IncreasePartnerViolence.pdf
National	Know your IX	advocacy org	no		references section in	sv	link	https://www.knowyourix.org/stateplay-playbook/prevention/
National	American School Health Association	advocacy org	no		in human trafficking	sv	link	http://www.ashaweb.org/wp-content/uploads/2017/08/ASHAHT-HealthEducatorSchoolsHT-2017.pdf
National	Psychiatric Times	professional development	no		references section	sv	link	http://www.psychiatrictimes.com/psychopharmacology/how-psychiatrists-can-prevent-fire-transmission-pre-and-post-exposure-prophylaxis-psep/p01
National	White House. Gov	National Government Website	yes	5/5/2017	described in longer r	sv	link	https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Documents/5.3.17%20Event%20Report.PDF
National	Kids ta.org (technical assistance for pediatric s	professional development	no		resources page	sv	link	http://www.kidsta.org/?page=1?pmid=formed2x1
internatio	rtenclas medicas news	individual blog	no	4/26/2017	blog post	sv	link	https://elderabilitypodcom.blogspot.fr/2016/04/cdc-releases-stop-sv-technical-package.html
UT	Utah Department of Health	State Government Website	no		references	sv	link	https://bci.health.utah.gov/indicator/homelate_portlet/Page.html
IA	University of Iowa Office of Sexual Misconduct	university service provider	no		references	sv	link	https://osmr.uiowa.edu/anti-violence-coalitions/anti-violence-plan
IL	Illinois Board of higher Education	State Government Website	no		part of larger article	sv	link	https://ibhe.org/vse/preventing-school-safety/
CO	Colorado School Safety Resource Center	State Government Website	no		resources section	sv	link	http://www.colorado.gov/pacific/cssrc/statistics-research
National	Battered Women's Justice Projet	Resource Clearinghouse	HHS		resources section	sv	link	http://www.bwjp.org/resource-center/resource-results.html
TN	University of Tennessee Chattanooga	university research center	no		Slides for a criminal j	sv	link	https://www.utc.edu/criminal-justice/pdfs/prevtestand.pdf
IA	Grinnell College	university research center	no		alcohol policy change	sv	link	https://www.grinnell.edu/news/alcohol-policy-changes
National	center for changing our campus culture	university research center	DOJ		resources section	sv	link	http://changingourcampusculture.org/about-us/vice-voices/
Canada	Center for Research and Education on Violence	university research center	no	5/2/2016	resources section	sv	link	http://www.vawlearningnetwork.ca/recently-added-resources
National	apaltical.co	professional development	no	11/10/2017	references section o	sv	link	https://apaltical.co/solution_article/want-prevent-sexual-harassment-assault-start-treating-rape/
internatio	global sexual violence resource network	Resource Clearinghouse	no		resources section	sv	link	http://www.gsvrn.org/category/english/
National	American Psychological Association	professional development	no		resources section	sv	link	http://www.apa.org/advocacy/interpersonal-violence/resources
Canada	Bystander Initiative @ UWindsor	university research center	no		reference	sv	link	http://bystanderinitiative.com/research/whysystander/
National	National Center on Domestic and Sexual Violen	advocacy org/community of practice/res	no		resources section	sv	link	http://www.ncdsv.org/publications_Sexual-Violence_Assault.html
VA	Community Solutions to Sexual and Domestic V	Resource Clearinghouse	no		resources section	sv	link	http://www.communitysolutionsva.org/index.php/resources/category/by-topic
MD	Readiness and Emergency Management for Schools	Technical Assistance Center	DOE		resources section	sv	link	https://www.communitysolutionsva.org/index.php/resources/category/by-topic
Canada	Can Prevent GBV	community of practice	no		resources section	sv	link	https://www.canpreventgbv.ca/think/#which-resources-are-right-for-me/
internatio	Know Violence in Childhood	advocacy org	no		resources section	CAN	pdf	http://www.knowviolenceinchildhood.org/portal/assets/pdf/CECCS%20Toolkit%20Statewide%20Presentation.pdf
National	National Children's Advocacy Center	non-profit	no		resources section	CAN	link	https://calio.gov.au/docs/publications/risk-and-protective-factors-child-abuse-and-neglect
South Afr	Center for justice and crime prevention	Resource Clearinghouse	no		resources section	CAN	link	https://www.violenceprevention.org.za/preventing-child-abuse-neglect-technical-package-policy-norm-programmatic-activities/
internatio	OCV Support	community of practice	USAID	27-Jun-17	resources section	CAN	link	https://ocvsupport.org/resources/preventing-child-abuse-and-neglect-a-technical-package-for-policy-norm-and-programmatic-activities/
LA	Childrens Law Advocacy Resources Online	Resource Clearinghouse	no		resources section	CAN	link	http://www.clarolin.org/resources/item/1214-preventing-child-abuse-and-neglect-a-technical-package-for-policy-norm-and-programmatic-activities
MD	Safe Environment for Every Kid	National Government Website	no		Their program was cl	CAN	link	https://www.safeandhealthy.org/copy-of-in-the-news
VA	Champions for Children Prevent Child Abuse Hampton Roads		no		resources section	CAN	pdf	http://www.championsforchildrenhr.org/cdc-can-prevention/
internatio	Information for Practice	Social worker resource clearing house o	no		resources section	CAN	link	http://ifp.nyu.edu/2017/guidelines-plus/preventing-child-abuse-neglect-technical-package-policy-norm-programmatic-activities-2/
National	AIDS Connection	interest website for AIDS related events	no		ad for a webinar wit	CAN	link	https://www.aidsconnection.com/event/mmc-bowen-bay-webinar-with-melissa-merrick-phd-preventing-child-abuse-and-neglect-a-technical-package-for-policy-norm-and-programmatic-activities
New Zeal	New Zealand Family Violence Clearinghouse	Violence Prevention Resource clearing l	no		resources section	CAN	link	https://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=8582
National	The Nation's Health/APHA	Newsletter	no	Jul-17	article about the TP	CAN	link	http://thenationshealth.aphapublications.org/content/47/5/18.3.full
National	Safety UI	Resource Clearinghouse	no		resources section	CAN	link	http://www.safetyui.org/citations/index.php?SearchStr=&criteria=relatedTo&criteriaOid=&75589%5B%5D=&report_258_7
Australia	Australian Institute of Family Studies	National Government Website	no		resources section	CAN	link	https://aifs.gov.au/cfca/publications/risk-and-protective-factors-child-abuse-and-neglect
Armenia	Armenian End Violence Against Children	National NGO	no		resources section	CAN	link	http://mamayturun.am/eng/resursy-eng/1228
PA	Pennsylvania Family Support Alliance	State NGO	no		factsheet	CAN	link	http://www.pa-fsa.org/About-Us/Documents/Child-Abuse-Neglect-in-Pennsylvania-Research-on-Child-Abuse-and-Neglect
National	National Criminal Justice Reference Service	National Government Website	DOJ		resources section	CAN	link	https://www.ncjrs.gov/childabuse/prevention.html
National	The National Child Traumatic Stress Network	National NGO	no	Apr-17	factsheet	CAN	link	http://www.nctsn.org/resources/public-awareness/national-child-abuse-prevention-month
WA	Washington State Governor's page	State Government Website	no		resources section	CAN	pdf	http://www.governor.wa.gov/sites/default/files/documents/PRCCT_20160614_BridgingBarriers_can_prevention_technical_package.pdf
WA	Committee for Children	State NGO	no		reference for child sa	CAN	link	http://www.cfchildren.org/policy-advocacy/child-sexual-abuse-prevention/
National	Child Welfare Information Gateway	Resource Clearinghouse	HHS, Administration for		resources section	CAN	link	https://www.childwelfare.gov/topics/systemwide/laws-policy/preventing/
internatio	Sexual Violence Research Initiative	Resource Clearinghouse	no		resources section	CAN	link	http://www.svri.org/documents/prevention-0
internatio	New England Journal of Medicine	Scientific Journal	CDC	Jul-17	references for Deb h	CAN	link	http://www.nejm.org/doi/full/10.1056/NEJMsb1702343?ref=#t=articleSuccessRemark
OH	Ohio Network of Children's Advocacy Centers	NGO	no		resources section	CAN	link	http://www.oncac.org/resources/research/
GA	Georgia Division of Family and Children Service	State Government Website	no		resources section	CAN	link	https://dfcs.georgia.gov/safe-and-national-links
National	NACDHO	National Network	no	14-Apr-17	child abuse prevention	CAN	link	https://nacdhonotice.naccho.org/2017/04/24/national-child-abuse-prevention-month-building-community-solutions-page/
National	American Academy of Pediatrics	national network	no	17-May-16	news section	CAN	link	http://www.aappublications.org/news/2016/05/17/PREC171 6
IN	Indiana State Government	State Government Website	no		resources section	CAN	link	http://www.in.gov/cwb/files/Child_Maltreatment.pdf
National	Psychology Today	Resource Clearinghouse	no	12/28/2016	references section fo	CAN	link	https://www.psychologytoday.com/blog/prose-kids-and-courts/201612/physical-punishment-and-science
National	parenting & child resources	Resource Clearinghouse	no		resources section	CAN	link	https://positivegrit.com/physics-punishment-results-less/
National	Action Teen to End Hitting Children	advocacy org	no		blog post about cdc s	CAN	link	http://www.actiontoendhitting.org/?q=resources/477-finally-the-center-of-disease-control-speaks-out-against-corporal-punishment
IN	Indiana Early Learning Advisory Committee	advocacy org	no		news section	CAN	link	http://www.eyedrdiana.org/featured-early-learning-news/
CO	Violence and Injury prevention network	community of practice	no	18-Apr-17	news section	CAN	link	https://vipnetworkmeetworkco.com/2017/04/apr18-a-nationwide-child-abuse.html
LA	Prevent Child Abuse Louisiana	advocacy org	no		resources section	CAN	link	https://pcal.org/prevention/cdc-strategies/
PA	Frankie's World	child-focused business	no	19-Apr-17	child abuse prevention	CAN	link	https://frankieworld.com/2017/04/19/26603/
National	Stephani E Leaming.	Resource Clearinghouse	no	27-Dec-16	short blurb	CAN	link	https://stephanieleaming.com/2016/12/27/preventing-child-abuse-and-neglect-abusive-head-trauma-series/
NM	Abilene Reporter-News	newspaper	no	17-Dec-16	news article about pa	CAN	link	http://www.reporternews.com/story/news/local/2016/12/17/preventing-child-abuse-requires-societal-approach/95342628/
CO	Colorado Essentials for Childhood	community of practice	CDC	18-Apr-17	blog post about child	CAN	link	http://www.coessentials.org/2017/04/april-is-national-child-abuse.html
National	Prevent IPV	Resource Clearinghouse	no	29-Jun-17	short blurb	IPV	link	https://preventipv.org/news/preventing-intimate-partner-violence-across-lifespan-technical-package-programs-policies-and
National	National Institute of Corrections	DOJ	no		short blurb	ips	link	https://nicic.gov/preventing-intimate-partner-violence-across-lifespan-technical-package-programs-policies-and
National	VAWnet	Resource Clearinghouse	no	May-17	short blurb	IPV	link	https://vawnet.org/material/preventing-intimate-partner-violence-across-lifespan-technical-package-programs-policies
National	Safe States	community of practice	CDC	22-May-17	news section	IPV	link	http://www.safestates.org/news/748186/CDC-Releases-Technical-Package-Intimate-Partner-Violence-Across-the-Lifespan.htm
IL	Illinois Public Health Association	community of practice	no	25-May-17	news section	IPV	link	https://www.ipha.com/news/post/929/cdc-releases-preventing-intimate-partner-violence-across-the-lifespan
National	Catholic Charities	International NGO	no	Jun-17	resources section	IPV	PDF	https://www.catholiccharitiesusa.org/wp-content/uploads/2017/06/CDC-Guide-to-Preventing-Domestic-Violence-2017.pdf

National	Youth.Gov	National Government Website	yes		resources section	IPV	link	https://youth.gov/federal-links/resource-preventing-intimate-partner-violence-across-lifespan-technical-package
National	Violence Against Women Learning Network	Resource Clearinghouse	no		resources section	IPV	link	http://www.vawlearningnetwork.ca/areas/preventing-intimate-partner-violence-across-lifespan-technical-package-progress-policy-and
Internatio	Sexual Violence Research Initiative	Resource Clearinghouse	no	27-Jun-17	resource section	IPV	link	http://www.svri.org/documents/communityplanet
CA	California Coalition against sexual Assault	community of practice	no	Jul-17	blog post advertising	IPV	link	https://www.calcasa.org/2017/07/the-many-hats-of-feminist-join-us-at-the-a-call-to-men-2017-national-conference/
National	PreventConnect	community of practice	no	22-May-17	news section	IPV	link	https://www.preventconnect.org/2017/05/new-report-on-strategies-to-prevent-domestic-violence/
National	SafeTA.org	technical assistance	no		events section ubrer	IPV	no link	https://www.safeta.org/events/EventDetails.aspx?id=670476
OH	Ohio Mens Action Network	advocacy org	no		Resources section	IPV	link	http://ohmenalic.org/
National	SAMHSA-HRSA Center for Integrated Health Sol	Resource Clearinghouse	HHS, SAMHSA, HRSA		IPV prevention article	IPV	link	https://www.integration.samhsa.gov/clinical-practice/intimate-partner-violence
National	SAMHSA	National Government Website	SAMHSA		resources section	IPV	link	https://www.samhsa.gov/women-children-families/publications-resources
New Zeal	New Zealand Family Violence Clearinghouse	Resource Clearinghouse	no		resources section	IPV	link	https://nzfvc.org.nz/?q%5Bfilters%5D%5Bpublication%5D=within-IPV-and-CAN
National	National Center on Domestic and Sexual Violen	community of practice	no		Resources section	IPV	link	http://www.ncdsv.org/publications_prevention.html
National	Youth.Gov	National Government Website	yes		resources section	YV	link	https://youth.gov/federal-links/ensure-comprehensive-technical-package-prevention-youth-violence-and-associated-risk
New Zeal	New Zealand Family Violence Clearinghouse	Resource Clearinghouse	no		resources section	YV	link	https://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=5282
National	City Match	community of practice	no	12/9/2017	resources section	YV	link	https://www.citymatch.org/publication/inner-room/1496/report-comprehensive-technical-package-prevention-youth-violence-and-
National	Information for Practice	Resource Clearinghouse	no	12/22/2017	resources section	yv	link	http://ifp.mssa.edu/2016/guidelines-plan/comprehensive-technical-package-prevention-youth-violence-associated-risk-behaviors/
National	National Network of Hospital-based Violence p	community of practice	no		resources section	yv	link	http://nnhvp.org/research-information-for-resource-page/
National	Stopbullying.gov	National Government Website	hhs	6/14/2017	news section	yv	link	https://www.stopbullying.gov/blog/2017/06/14/new-cdc-resource-can-help-states-and-communities-prevent-youth-violence.html
National	Safe States	community of practice	hhs	12/7/2016	news section	yv	link	http://www.safestates.org/news/312133/AVERTED-A-Technical-Package.htm
National	National Wraparound Initiative	university reserch center	no	6/28/2017	resources section	yv	link	https://nwi.pdx.edu/resources-tips-cdc-to-stop-bullying/
Italy	ASPIC Verona	professional development	no	10/8/2017	resources section	yv	link	http://www.unprevenire.org/youth-violence-just-arrive-in-america
NY	New York State Center for School Health	professional development	no	17-Jun-17	resources section	yv	link	https://www.schoolhealthny.com/cms/?option=com_dailyplanetblog&view=entry&year=2017&month=06&day=14&id=6:new-cdc-technical-package-to-prevent-youth-violence-and-associated-risk-behaviors
National	Office of Justice Programs	technical assistance	DOJ		resources section	yv	link	https://www.ojjdp.gov/mpg/blog/preventing-youth-violence-prevents-child%E2%80%99s-technical-package-can-help
TX	Texas Department of State Health Services	State Government Website	no	11-Jun-17	weekly newsletter	yv	link	https://www.dshs.texas.gov/uploadedFiles/Content/... /Friday%20Brief-20170111.docx
IL	Illinois School and Campus Safety Resource Cen	Resource Clearinghouse	no		resources section	yv	link	http://schoolsafety.org/index.php/k-12-resources/school-violence/school-violence
Internatio	Youth Alert	advocacy org	no		resources section	yv	link	https://www.youthalert.ca/_index.php
WA	King County Health Department	State Government Website	no		resources section	yv	link	https://www.kingcounty.gov/depts/health/violence-injury-prevention/~/media/depts/health/violence-injury-prevention/documents/child-and-youth-violence-and-injury-prevention.ashx
PA	Pennsylvania Commission on crime and delique	State Government Website	no	21-Dec-16	newsletter	yv	link	www.pccd.pa.gov/Victim-Services/.../Y9%20Newsletter%2012-21-16.docx
WV	The Intelligencer, Wheeling News-Register	newspaper	no	8/7/2017	news article about sc	yv	no link	http://www.theintelligencer.net/Top-Stories/2017/08/cdc-offers-school-safety-tips#ENZ9R9kBBTs.ucrbs/
National	National After School Association	professional development	no	8/15/2017	resource section	yv	link	https://naaweb.org/professional-development/item/778-the-resources-you-need-to-promote-tolerance-and-inclusion
NJ	Warshaw Law Firm	child-focused business	no		resource section	yv	link	https://www.warshawlawfirm.com/blog/news/cdc-resources-can-help-states-and-communities-prevent-youth-violence/
VA	River Country News	newspaper	no	24-Dec-17	news article about bi	yv	link	https://www.rivercountynews.com/34321/p/article/view
National	National Association of School Psychologists	professional development	no		newsletter	yv	link	https://www.nasponline.org/professional-development/prepare-training-curriculum/prepare-training/prepare-newsletter/issueno-8-may-5/five-tips-to-prepare-for-the-school-year
CO	Colorado School Safety Resource Center	State Government Website	no		resource section	yv	link	https://www.colorado.gov/pacific/cssrc/bullying-harassment
OK	PepTalkOK	State RPC website	no		resource section	yv	link	http://peptalkok.com/faq/
OK	State Department of Education	State Government Website	no		resource section	YV	link	http://sde.ok.gov/sde/youth-violence-prevention
CA	UCLA Center for MH in Schools & sfudentlearni	university reserch center	no		resource section	yv	link	http://smhp.psych.ucla.edu/qf/prevention.htm
national	schoolsafetyinfo.org	Resource Clearinghouse	no		resource section	yv	link	https://schoolsafetyinfo.org/resources/prepare-tips-school.html

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 5 May 2018 12:58:48 -0400
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: FW: veteran suicide
Attachments: DStone_Figure 1.emf, VS_Suicide_5.4.18 clean.docx, TABLE 2_New 5.4.18.docx, TABLE 1_New 5.4.18.docx, DStone_Supplemental Table 1.pdf, TABLE 1_New 5.4.18.docx

Resending because I did not include Deb.
Hi J.,
The VS MMWR (attached) is not about military/Veteran Suicide but there is one line in the table showing the proportion of decedents who have served in the military (see Table 1).
The Surgeon General is going to participate in the telebriefing for the VS and he is likely to make a point about the high risk among Veterans and the need for prevention. This could generate some questions for us from the media.
I'm glad that you have q's and a's to choose from. I don't seem to be able to access the Q's and A's on Sharepoint. If you could send us a few Q's and A's with short answers to questions you think will come up related to trends, prevention strategies, what CDC is doing, etc. that will be helpful. You have a better sense of what comes up most often.
We have a pre-briefing with Dr. Schuchat on Tuesday and, if possible, it would be good for us to have these with us in case it comes up. The actual launch is not until 6/7 though so we have time to finalize this once we see exactly what the SG intends to say.
Thank you!
-Tom

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: Saturday, May 5, 2018 9:15 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: veteran suicide

Hi Tom,
If you can give me a few days, I can help. If you need the Q and As immediately, then feel free to draw from the documents I posted on SharePoint. Just note, on Monday morning, I plan to update them in prep for Marcus so please wait on accessing them until noonish. We've had some significant enhancements that I need to include. All I ask is that if you can please send the Q and As to me before sending them up the chain, I would appreciate it. I just want to keep an eye on what we release so we don't accidently repeat the events of the last few weeks.
If you would like my help with drafting them, then please send me any background materials (Vital Signs drafts, fact sheets etc) so I understand the context. There are a lot of different ways the Q and As can go and so I might be able to narrow the scope of possible key relevant questions and messages if I have more background.
J.

J. Logan, Ph.D.
Suicide and Youth Violence, Emerging Topics (SaYVE) Team
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From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 4, 2018 11:54 AM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: veteran suicide

Hi J.,
We are compiling q's and a's for the upcoming vital signs. Do you have any q's and a's related to Veteran suicide that we can pull from?
The Surgeon General is participating in the launch and he is particularly interested in Veteran suicide.
I think short answers to questions about trends, prevention strategies, and what CDC is doing will be helpful.
Thank you!
-Tom

5.4.18

Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

Deborah M. Stone, ScD[1]; Thomas R. Simon PhD[1]; Katherine A. Fowler, PhD[1]; Scott R. Kegler, PhD[2]; Keming Yuan, MS[1]; Kristin M. Holland, PhD[1]; Asha Z. Ivey-Stephenson, PhD[1]; Alex E. Crosby, MD[1]

Background: Suicide rates in the United States have risen nearly 30% since 1999, and mental health problems are just one factor contributing to suicide. Examining state-level trends in, and the multiple circumstances contributing to, suicide can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among persons aged ≥10 years, by state and sex, across six consecutive three-year periods (1999–2016), were assessed using data from the National Vital Statistics System for 50 states and the District of Columbia (DC). Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health problems.

Results: During 1999–2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases of more than 30%. Rates increased significantly among males and females in 34 and 43 states, respectively. In 2015, more than half (54%) of decedents in 27 states did not have a known mental health problem. Among persons with circumstance information, several circumstances were significantly more likely among those without a known mental health problems than among decedents with mental health problems, including relationship problems/loss (45.1% vs 39.6%), life stressors (54.2% vs 49.7%), and recent/impending crises (32.9% vs 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states during 1999–2016. Various circumstances contributed to suicides among persons with and without known mental health problems.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends/family after a suicide occurs.

INTRODUCTION

BACKGROUND AND PURPOSE

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States, among persons aged ≥10 years (*1*). Between 1999 and 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (*2,3*). Suicide is the 10th leading cause of death and is one of just three leading causes that are increasing (*1,4*). Additionally, rates of emergency department visits for nonfatal self-harm, a key risk factor for suicide, increased 42% between 2001 and 2015 (*1*). Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs (*1*).

The *National Strategy for Suicide Prevention (NSSP)* (*5*) calls for a public health approach to suicide prevention with efforts spanning multiple levels (i.e., individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is determined by multiple factors. Despite the NSSP guidance, suicide prevention largely focuses on identifying suicidal persons, providing treatment for mental health problems and preventing reattempts (*6*). In addition to mental health problems and prior attempts, other circumstances contributing to suicide include social and economic

problems, access to lethal means (e.g., substances, firearms) among persons at risk, and poor coping and problem-solving skills (*5*). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them can help reach the nation's goal of reducing suicide rates 20% by 2025 (*7*). To assist states in achieving this goal, CDC analyzed state-specific trends in suicide rates, assessed the multiple contributing factors to suicide, and presents options for multi-level comprehensive suicide prevention based on the best available evidence.

METHODS

Suicide rates were analyzed for persons aged ≥10 years only, as determining suicidal intent in younger children can be difficult (*8*). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases 10th Revision,* underlying-cause-of death codes X60–X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive three-year aggregate periods spanning 1999–2016 (1999–2001, 2002–2004; 2005–2007; 2008–2018; 2011–2013; and 2014–2016). Rate estimates were age-adjusted to the U.S. year 2000 standard population and expressed per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same three-year data aggregates, employing weighted least squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes (AAPCs).

Characteristics and circumstances of persons aged ≥10 years who died by suicide, with and without known mental health problems, were compared in the 27 states with complete data

participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines mental health problems as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (*9*), with the exception of alcohol and other substance use disorders, which are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. Decedents with and without known mental health problems were compared using Chi-square tests. Logistic regression analyses estimated adjusted odds ratios with 95% confidence intervals (CI), controlling for age group, sex, and race/ethnicity.

RESULTS

The most recent overall suicide rates (representing 2014–2016) varied four-fold, from 6.9 (DC) to 29.2 (Montana) per 100,000 persons per year (available online). Across the study period, rates increased in all states except Nevada (which had a consistently high rate throughout), with absolute increases ranging from +0.8 per 100,000 (Delaware) to +8.1 (Wyoming). Percentage increases in rates ranged from +5.9% (Delaware) to +57.6% (North Dakota), with increases of more than 30% observed in 25 states (available online; Figure 1).

Modeled suicide rate trends indicated significant increases in 44 states, among males (34 states) and females (43 states), as well as for the United States overall (available online). Nationally, the model-estimated AAPC for the overall suicide rate was +1.5%. By sex, estimated national rate trends further indicated significant increases for males (AAPC +1.1%) and females (AAPC +2.6%) (available online).

Suicide decedents without known mental health problems (N = 11,039) were compared with those with known mental health problems (N = 9,407) in 27 states. Whereas all decedents were predominately male (76.8%) (Table 1) and non-Hispanic white (83.6%), those without known

mental health problems, relative to those with mental health problems, were more likely male (83.6% versus 68.8%; odds ratio (OR) = 2.3, 95% CI = 2.2–2.5) and racial/ethnic minorities (OR range: 1.2–2.0). Suicide decedents without known mental health problems also had significantly higher odds of perpetrating homicide-suicide (adjusted odds ratio (aOR) = 2.9, 95% CI = 2.2–3.8). Among adult decedents ≥18 years, 20.1% of those without known mental health problems and 15.3% of those with mental health problems had ever served, or were currently serving, in the U.S. military.

Whereas firearms were the most common method of suicide overall (48.5%) and for decedents with and without mental health problems, decedents without known mental health problems were more likely to die by firearm (55.3% versus 40.6%) and less likely to die by hanging/strangulation/suffocation (26.9% versus 31.3%) or poisoning (10.4% versus 19.8%) than were those with known mental health problems. These differences remained significant in the adjusted models.

Decedents without known mental health problems were less likely to receive toxicology testing. Among those with toxicology results, decedents without known mental health problems were less likely to test positive for any substance overall (aOR = 0.8, 95% CI = 0.7–0.8), including opioids (aOR = 0.90 95% CI = 0.81–0.99), but were more likely to test positive for alcohol (aOR = 1.2, 95% CI = 1.1–1.3).

Information on circumstances surrounding suicide were available for all decedents with mental health problems (N = 9,407) and approximately 85% of those without known mental health problems (N = 9,357) (Table 2). Persons without known mental health problems were less likely to have any substance use disorders (aOR = 0.7, 95% CI = 0.7–0.8). Whereas two thirds of

decedents with known mental health problems had a history of mental health or substance use treatment (67.2%), just over half (54.0%) were in current treatment.

Decedents without known mental health problems had a significantly higher likelihood of any relationship problem/loss (45.1%) than did those with known mental health problems (39.6%), specifically intimate partner problems (30.2% versus 24.1%), arguments/conflicts (17.5% versus 13.6%), and recently perpetrating interpersonal violence (3.0% versus 1.4%). Decedents without known mental health problems were also more likely than those with known mental health problems to have experienced any life stressors (54.2% versus 49.7%) such as criminal-legal problems (10.7% versus 6.2%) or eviction/loss of home (4.3% versus 3.4%) and were more likely to have had a crisis a current or acute event thought to contribute to the suicide, within the preceding or impending, two weeks (32.9% versus 26.0%). All of these differences remained significant in the adjusted models. Among all persons with recent crises, intimate partner problems were the most common types and did not differ by group. Similarly, physical health problems and job/financial problems were commonly experienced among both persons without mental health problems (23.2% and 15.6%, respectively) and those with mental health problems (21.4% and 16.8%, respectively).

Decedents without known mental health problems had significantly lower odds of recent release from any institution (aOR = 0.5, 95% CI = 0.4–0.5), but those who were recently released (5.1%), were significantly more likely to have been released from a correctional facility (25.7% versus 8.7%), hospital (43.7% versus 33.0%), or other facility (e.g., alcohol/substance treatment) (aOR = 2.5 95% CI = 1.8–3.3), than those with a known mental health problems. Among decedents with known mental health problems who were recently released from an institution (10.2%), 46.7% of were released from psychiatric facilities.

Decedents without known mental health problems were significantly less likely to have a history of suicidal ideation (23.0%) or prior suicide attempts (10.3%) compared with those with known mental health problems (40.8% and 29.4%, respectively). Suicide intent was disclosed by 22.4% and 24.5% of persons without and with known mental health problems, respectively.

Conclusions and Comments

During 1999–2016, suicide rates increased significantly in 44 states, and 25 states experienced increases of more than 30%. Rates increased significantly among males in 34 states, and females, in 43 states. This finding is consistent with prior research showing a decreasing gender gap in male-female suicide rates during 1999–2014 (*3*). Additional research into the specific causes of these trends is necessary. Fortunately, data from the 27 states participating in NVDRS provides important insight into circumstances surrounding suicide and can help states identify prevention priorities.

Suicidologists regularly state that suicide is not caused by a single factor (*5*); however, suicide prevention is often oriented toward downstream identification of suicidal persons, treatment of mental health problems and prevention of reattempts. This study found that more than half of suicide decedents in NVDRS did not have a known mental health problems, indicating that additional focus on non-mental health factors, further upstream, is essential to a public health approach (*10*). This group suffered more from relationship problems and other life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises.

Similarly, persons with mental health problems often experienced relationship problems and other life stressors such as job/financial and/or physical health problems. These findings point to the need to both help persons manage the conditions associated with mental health problems in the first place, and to support persons with known mental health problems to decrease their risk

of poor outcomes (*11*). Two thirds of this group had a history of any mental health and/or substance use treatment, with over half in treatment when they died. This suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, increased access to behavioral health providers in underserved areas is needed, as is expansion of health care systems that integrate physical and behavioral health, with a priority on suicide prevention and patient safety, especially through care transitions (*12*).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belonging and access to informational, tangible, emotional, and social support; and identifying and better supporting persons at risk (e.g., military veterans, persons with physical/mental health problems) (*12*). Other strategies include creating protective environments (e.g., reducing access to lethal means among persons at risk, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for persons with mental health problems and other life challenges), supporting family and friends after a suicide, and assuring safe reporting by the media in order to prevent suicide contagion (*12*). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (*10*).

The findings in this report are subject to at least three limitations. In the state-level analysis, rankings for four states (Maryland, Massachusetts, Rhode Island, and Utah) might have been

affected by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward), or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml). Finally, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often identify greater attributions to mental disorders (*13*); however, many methodological variations across studies exist (*14*). It is likely that some persons without known mental health problems in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health problems suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices* (*12*) to better understand their suicide problem, prioritize evidence-based comprehensive suicide prevention, and save lives.

Acknowledgments

Robert Anderson, Holly Hedegaard, and Margaret Warner, Division of Vital Statistics, National Center for Health Statistics, CDC.

Conflict of Interest No conflicts of interest were reported.

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Summary Box (word count 100/100)

What is already known on the topic?

In 2016, nearly 45,000 lives were lost to suicide in the U.S.

What is added by this report?

Between 1999-2016, suicide rates increased in nearly every state. Twenty-five states saw rate increases >30%. Mental health problems often contribute to suicide, however, 2015 data from the National Violent Death Reporting System (27 states) indicate that 54% of suicide decedents

were not known to have such problems. Other contributors included relationship, substance use, health, and job/financial problems.

What are the implications for public health practice?

A comprehensive approach using proven prevention strategies, such as those in CDC's Technical Package for Suicide Prevention, can help reach the national goal of reducing suicide rates 20% by 2025.

TABLE 2. Circumstances Preceding Suicide among Decedents Aged >10 years with and without known mental health problems — National Violent Death Reporting System, 27 states,* 2015

Characteristics	Total	Known mental health problem†, no. (%)	No known mental health problem, no. (%)	Chi–Square	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	18,764 (91.8)	9,407 (100)	9,357 (84.8)	p<0.01	—	—
Mental Health						
Any Current Diagnosed Mental Health Problem**						
Depression/dysthymia		7,076 (75.2)	—	—	—	—
Anxiety disorder		1,579 (16.8)	—	—	—	—
Bipolar disorder		1,431 (15.2)	—	—	—	—
Schizophrenia		509 (5.4)	—	—	—	—
PTSD		424 (4.5)	—	—	—	—
ADD/ADHD		226 (2.4)	—	—	—	—
Unknown		760 (8.1)	—	—	—	—
Current depressed mood		3,962 (42.1)	3,076 (32.9)	p<0.01	0.7 (0.6–0.7)	0.7 (0.6–0.7)
Substance Problems						
Any Current substance problem	5,319 (28.3)	2,976 (31.6)	2,343 (25.0)	p<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Alcohol problem	3,268 (17.4)	1,862 (19.8)	1,406 (15.0)	p<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Other substance problem	3,084 (16.4)	1,768 (18.8)	1,316 (14.1)	p<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Treatment						
Current mental health/substance abuse treatment	5,141 (27.4)	5,077 (54.0)	64 (0.7)	p<0.01	0.01 (0.01–0.01)	0.01 (0.01–0.01)
Ever treated for mental health/substance problem	6,717 (35.8)	6,323 (67.2)	394 (4.2)	p<0.01	0.02 (0.02–0.02)	0.02 (0.02–0.03)
Relationship Problems/Loss						
Any relationship problem/loss	7,948 (42.4)	3,726 (39.6)	4,222 (45.1)	p<0.01	1.3 (1.2–1.3)	1.3 (1.2–1.4)
Intimate partner problem	5,098 (27.2)	2,270 (24.1)	2,828 (30.2)	p<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Perpetrator of interpersonal violence in past month	414 (2.2)	131 (1.4)	283 (3.0)	p<0.01	2.2 (1.8–2.7)	2.0 (1.6–2.4)
Victim of interpersonal violence in past month	84 (0.4)	53 (0.6)	31 (0.3)	p<0.05	0.6 (0.4–0.9)	0.8 (0.5–1.2)
Family relationship problem	1,671 (8.9)	873 (9.3)	798 (8.5)	—	0.9 (0.8–1.0)	1.0 (0.9–1.1)
Other relationship problem (non–intimate)	403 (2.1)	202 (2.1)	201 (2.1)	—	1.0 (0.8–1.2)	1.1 (0.9–1.3)
Argument or conflict (not specified)	2,914 (15.5)	1,278 (13.6)	1,636 (17.5)	p<0.01	1.3 (1.2–1.5)	1.4 (1.3–1.5)
Death of a loved one (any)	1,497 (8.0)	826 (8.8)	671 (7.2)	p<0.01	0.8 (0.7–0.9)	0.9 (0.8–0.9)
Non–suicide death	1,181 (6.3)	647 (6.9)	534 (5.7)	p<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Suicide of family or friend	379 (2.0)	217 (2.3)	162 (1.7)	p<0.01	0.7 (0.6–0.9)	0.8 (0.7–1.0)
Other Life Stressors						
Any life stressor	9,743 (51.9)	4,675 (49.7)	5,068 (54.2)	p<0.01	1.2 (1.1–1.3)	1.1 (1.1–1.2)
Recent criminal legal problem	1,588 (8.5)	586 (6.2)	1,002 (10.7)	p<0.01	1.8 (1.6–2.0)	1.7 (1.5–1.9)
Other legal problem	748 (4.0)	378 (4.0)	370 (4.0)	—	1.0 (0.8–1.1)	1.0 (0.9–1.2)
Physical health problem	4,179 (22.3)	2,012 (21.4)	2,167 (23.2)	p<0.01	1.1 (1.0–1.2)	1.0 (1.0–1.1)
Job/Financial problem††	2941 (16.2)	1530 (16.8)	1411 (15.6)	p<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Eviction or loss of home	722 (3.8)	317 (3.4)	405 (4.3)	p<0.01	1.3 (1.1–1.5)	1.4 (1.2–1.6)
School problem§§	162 (19.9)	70 (17.8)	92 (21.9)	—	1.3 (0.9–1.8)	1.3 (0.9–1.9)
Recent release from an institution¶¶	1,412 (7.6)	941 (10.2)	471 (5.1)	p<0.01	0.5 (0.4–0.5)	0.5 (0.4–0.5)
Jail/prison/detention facility	203 (14.4)	82 (8.7)	121 (25.7)	p<0.01	3.6 (2.7–4.9)	4.5 (3.2–6.4)
Hospital	517 (36.6)	311 (33.0)	206 (43.7)	p<0.01	1.6 (1.3–2.0)	1.3 (1.0–1.7)
Psychiatric hospital/institution	469 (33.2)	439 (46.7)	30 (6.4)	p<0.01	0.1 (0.1–0.1)	0.1 (0.1–0.1)
Other (includes alcohol/SA treatment facilities)	223 (15.8)	109 (11.6)	114 (24.2)	p<0.01	2.4 (1.8–3.3)	2.5 (1.8–3.3)
Recent or Impending Crisis						
Crisis within past or upcoming 2 weeks***	5,525 (29.4)	2,444 (26.0)	3,081 (32.9)	p<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Intimate partner problem crisis	1968 (35.6)	854 (34.9)	1114 (36.2)	—	1.1 (0.9–1.2)	1.1 (0.9–1.2)
Physical health problem crisis	739 (13.4)	315 (12.9)	424 (13.8)	—	1.1 (0.9–1.3)	1.0 (0.8–1.2)
Criminal legal problem crisis	621 (11.2)	203 (8.3)	418 (13.6)	p<0.01	1.7 (1.5–2.1)	1.6 (1.3–1.9)
Family relationship problem crisis	430 (7.8)	212 (8.7)	218 (7.1)	p<0.05	0.8 (0.7–1.0)	0.9 (0.7–1.1)
Job problem crisis	354 (6.4)	191 (7.8)	163 (5.3)	p<0.01	0.7 (0.5–0.8)	0.7 (0.5–0.8)
Suicide Event/History						
Left a note	6,468 (34.5)	3,182 (33.8)	3,286 (35.1)	—	1.1 (1.0–1.1)	1.2 (1.1–1.2)
Disclosed suicide intent	4,405 (23.5)	2,306 (24.5)	2,099 (22.4)	p<0.01	0.9 (0.8–1.0)	0.9 (0.8–0.9)
History of ideation	5,990 (31.9)	3,838 (40.8)	2,152 (23.0)	p<0.01	0.4 (0.4–0.5)	0.4 (0.4–0.5)
History of attempts	3,732 (19.9)	2,770 (29.4)	962 (10.3)	p<0.01	0.3 (0.3–0.3)	0.3 (0.3–0.3)

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health problem in coroner/medical examiner or law enforcement reports.

§ Odds ratio reflects the risk among those without known mental health problem relative to those with known mental health problem.

¶ Logistic regression was used to estimate adjusted odds ratio with 95% CIs after controlling for age, sex, race and ethnicity. Known mental health problem was the reference group.

** Includes decedents with one or more diagnosed current mental health problems, which are not mutually exclusive. Therefore, sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health problems.

†† Denominator is decedents aged ≥18 years.

§§ Denominator is decedents aged 10–18 years.

¶¶ Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.
*** Denominator of crisis subgroup is decedents with any crisis within past or upcoming 2 weeks. Crises depicted here represent the most commonly occurring categories.

TABLE 1. Select demographic and descriptive characteristics of suicides aged ≥10 years with and without known mental health problems — National Violent Death Reporting System, 27 states,* 2015

Characteristics	Total (n = 20,446)	Known mental health problem† (n = 9,407)	No known mental health problem (n = 11,039)	Chi–Square	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	15,702 (76.8)	6,469 (68.8)	9,233 (83.6)	p<0.01	2.3 (2.2–2.5)	—
Female	4,744 (23.2)	2,938 (31.2)	1,806 (16.4)	p<0.01	0.4 (0.4–0.5)	—
Age (yrs)**						
10–24	2,804 (13.7)	1,211 (12.9)	1,593 (14.4)	p<0.01	1.1 (1.1–1.2)	—
25–44	6,456 (31.6)	3,036 (32.3)	3,420 (31.0)	p<0.05	0.9 (0.9–1.0)	—
45–64	7,718 (37.7)	3,820 (40.6)	3,898 (35.3)	p<0.01	0.8 (0.8–0.8)	—
≥65	3,468 (17.0)	1,340 (14.2)	2,128 (19.3)	p<0.01	1.4 (1.3–1.5)	—
Race/ethnicity						
White, non-Hispanic	17,102 (83.6)	8,165 (86.8)	8,937 (81.0)	p<0.01	0.6 (0.6–0.7)	—
Black, non-Hispanic	1,228 (6.0)	411 (4.4)	817 (7.4)	p<0.01	1.7 (1.5–2.0)	—
American Indian/Alaska Native, non-Hispanic	378 (1.8)	112 (1.2)	266 (2.4)	p<0.01	2.0 (1.6–2.6)	—
Asian, non-Hispanic	576 (2.8)	235 (2.5)	341 (3.1)	p<0.05	1.2 (1.1–1.5)	—
Hispanic	1,096 (5.4)	463 (4.9)	633 (5.7)	p<0.05	1.2 (1.0–1.3)	—
Other	66 (0.3)	21 (0.2)	45 (0.4)	p<0.05	1.8 (1.1–3.1)	—
Extended demographics						
Ever served in military††	3,429 (17.8)	1,354 (15.3)	2,075 (20.1)	p<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	240 (1.2)	104 (1.1)	136 (1.3)		1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident Type						
Single suicide	20,063 (98.2)	9,318 (99.1)	10,745 (97.4)	p<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	319 (1.6)	64 (0.7)	255 (2.3)	p<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	64 (0.3)	25 (0.3)	39 (0.4)	—	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	9,909 (48.5)	3,821 (40.6)	6,088 (55.3)	p<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	5,907 (28.9)	2,940 (31.3)	2,967 (26.9)	p<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	3,003 (14.7)	1,861 (19.8)	1,142 (10.4)	p<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	1,021 (34.0)	666 (35.8)	355 (31.1)	p<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	944 (31.4)	608 (32.7)	336 (29.4)	—	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	800 (26.6)	644 (34.6)	156 (13.7)	p<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	624 (20.8)	468 (25.1)	156 (13.7)	p<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	219 (7.3)	195 (10.5)	24 (2.1)	p<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	1,595 (7.8)	780 (8.3)	815 (7.4)	p<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Toxicology Results						
Any toxicology testing	13,317 (65.1)	6,658 (70.8)	6,659 (60.3)	p<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	9,913 (74.4)	5,192 (78.0)	4,721 (70.9)	p<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected***						
Alcohol						
Tested	10,950 (53.6)	5,409 (57.5)	5,541 (50.2)	p<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	4,442 (40.6)	2,115 (39.1)	2,327 (42.0)	p<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	8,554 (41.8)	4,258 (45.3)	4,296 (38.9)	p<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	2,279 (26.6)	1,238 (29.1)	1,041 (24.2)	p<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	8,124 (39.7)	4,226 (44.9)	3,898 (35.3)	p<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	2,464 (30.3)	1,639 (38.8)	825 (21.2)	p<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	7,978 (39.0)	3,866 (41.1)	4,112 (37.2)	p<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	499 (6.3)	216 (5.6)	283 (6.9)	p<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	7,615 (37.2)	3,696 (39.3)	3,919 (35.5)	p<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	736 (9.7)	376 (10.2)	360 (9.2)	—	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	6,569 (32.1)	3,127 (33.2)	3,442 (31.2)	p<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	1,471 (22.4)	710 (22.7)	761 (22.1)	—	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	5,425 (26.5)	3,103 (33.0)	2,322 (21.0)	p<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	2,214 (40.8)	1,735 (55.9)	479 (20.6)	p<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviation: CI = confidence interval.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health problem in coroner/medical examiner or law enforcement reports.

§ Odds ratio reflects the risk among those without known mental health problem relative to those with known mental health problem.

¶ Logistic regression was used to estimate adjusted odds ratio with 95% CIs after controlling for age, sex, race and ethnicity. Known mental health problem was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology tested.

*** Denominator for each positive group is the number tested for the substance in that group.

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30 ¶¶)	+ 34.1 % (23 ¶¶)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3 ¶¶)	+ 46.5 % (4 ¶¶)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Differences between ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

TABLE 1. Select demographic and descriptive characteristics of suicides aged ≥10 years with and without known mental health problems — National Violent Death Reporting System, 27 states,* 2015

Characteristics	Total (n = 20,446)	Known mental health problem† (n = 9,407)	No known mental health problem (n = 11,039)	Chi–Square	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	15,702 (76.8)	6,469 (68.8)	9,233 (83.6)	p<0.01	2.3 (2.2–2.5)	—
Female	4,744 (23.2)	2,938 (31.2)	1,806 (16.4)	p<0.01	0.4 (0.4–0.5)	—
Age (yrs)**						
10–24	2,804 (13.7)	1,211 (12.9)	1,593 (14.4)	p<0.01	1.1 (1.1–1.2)	—
25–44	6,456 (31.6)	3,036 (32.3)	3,420 (31.0)	p<0.05	0.9 (0.9–1.0)	—
45–64	7,718 (37.7)	3,820 (40.6)	3,898 (35.3)	p<0.01	0.8 (0.8–0.8)	—
≥65	3,468 (17.0)	1,340 (14.2)	2,128 (19.3)	p<0.01	1.4 (1.3–1.5)	—
Race/ethnicity						
White, non-Hispanic	17,102 (83.6)	8,165 (86.8)	8,937 (81.0)	p<0.01	0.6 (0.6–0.7)	—
Black, non-Hispanic	1,228 (6.0)	411 (4.4)	817 (7.4)	p<0.01	1.7 (1.5–2.0)	—
American Indian/Alaska Native, non-Hispanic	378 (1.8)	112 (1.2)	266 (2.4)	p<0.01	2.0 (1.6–2.6)	—
Asian, non-Hispanic	576 (2.8)	235 (2.5)	341 (3.1)	p<0.05	1.2 (1.1–1.5)	—
Hispanic	1,096 (5.4)	463 (4.9)	633 (5.7)	p<0.05	1.2 (1.0–1.3)	—
Other	66 (0.3)	21 (0.2)	45 (0.4)	p<0.05	1.8 (1.1–3.1)	—
Extended demographics						
Ever served in military††	3,429 (17.8)	1,354 (15.3)	2,075 (20.1)	p<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	240 (1.2)	104 (1.1)	136 (1.3)		1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident Type						
Single suicide	20,063 (98.2)	9,318 (99.1)	10,745 (97.4)	p<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	319 (1.6)	64 (0.7)	255 (2.3)	p<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	64 (0.3)	25 (0.3)	39 (0.4)	—	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	9,909 (48.5)	3,821 (40.6)	6,088 (55.3)	p<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	5,907 (28.9)	2,940 (31.3)	2,967 (26.9)	p<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	3,003 (14.7)	1,861 (19.8)	1,142 (10.4)	p<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	1,021 (34.0)	666 (35.8)	355 (31.1)	p<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	944 (31.4)	608 (32.7)	336 (29.4)	—	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	800 (26.6)	644 (34.6)	156 (13.7)	p<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	624 (20.8)	468 (25.1)	156 (13.7)	p<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	219 (7.3)	195 (10.5)	24 (2.1)	p<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	1,595 (7.8)	780 (8.3)	815 (7.4)	p<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Toxicology Results						
Any toxicology testing	13,317 (65.1)	6,658 (70.8)	6,659 (60.3)	p<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	9,913 (74.4)	5,192 (78.0)	4,721 (70.9)	p<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected***						
Alcohol						
Tested	10,950 (53.6)	5,409 (57.5)	5,541 (50.2)	p<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	4,442 (40.6)	2,115 (39.1)	2,327 (42.0)	p<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	8,554 (41.8)	4,258 (45.3)	4,296 (38.9)	p<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	2,279 (26.6)	1,238 (29.1)	1,041 (24.2)	p<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	8,124 (39.7)	4,226 (44.9)	3,898 (35.3)	p<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	2,464 (30.3)	1,639 (38.8)	825 (21.2)	p<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	7,978 (39.0)	3,866 (41.1)	4,112 (37.2)	p<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	499 (6.3)	216 (5.6)	283 (6.9)	p<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	7,615 (37.2)	3,696 (39.3)	3,919 (35.5)	p<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	736 (9.7)	376 (10.2)	360 (9.2)	—	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	6,569 (32.1)	3,127 (33.2)	3,442 (31.2)	p<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	1,471 (22.4)	710 (22.7)	761 (22.1)	—	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	5,425 (26.5)	3,103 (33.0)	2,322 (21.0)	p<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	2,214 (40.8)	1,735 (55.9)	479 (20.6)	p<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviation: CI = confidence interval.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health problem in coroner/medical examiner or law enforcement reports.

§ Odds ratio reflects the risk among those without known mental health problem relative to those with known mental health problem.

¶ Logistic regression was used to estimate adjusted odds ratio with 95% CIs after controlling for age, sex, race and ethnicity. Known mental health problem was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology tested.

*** Denominator for each positive group is the number tested for the substance in that group.

From: CDC Washington Office
Sent: 16 Mar 2018 16:14:06 -0400
To: CDC Washington Office
Subject: Legislative Report for CDC and ATSDR: March 16, 2018

Legislative Report for CDC and ATSDR: March 16, 2018

FLOOR ACTION

March 14 The House passed H.R.4909, the Student, Teachers, and Officers Preventing (STOP) School Violence Act of 2018.

COMMITTEE AND SUBCOMMITTEE ACTION

March 12 The House Oversight and Government Reform Interior, Energy, and Environment Subcommittee held a hearing on the 2017 hurricane season, to examine the impacts on the U.S. Virgin Islands.

The House Veterans' Affairs (VA) Health Subcommittee held a hearing to examine VA healthcare and maximizing resources in Puerto Rico.

March 14 The Senate Indian Affairs Committee held an oversight hearing to examine the opioid crisis in Indian Country.

The House Energy and Commerce (E&C) Health Subcommittee held a hearing to examine the reauthorization of animal drug user fees.

The House Science, Space, and Technology Committee held a hearing to focus on world-leading innovation in science, among national laboratories.

The Senate Foreign Relations Multilateral International Development, Multilateral Institutions, and International Economic, Energy, and Environmental Policy Subcommittee held a hearing to examine food security matters.

March 15 The House Appropriations Labor, Health and Human Services, Education, and Related Agencies Subcommittee held a hearing on HHS' Fiscal Year (FY) 2019 Budget. Secretary Alex Azar II testified on behalf of HHS.

The Senate Health, Education, Labor, and Pensions (HELP) Committee held a hearing to examine the 340B Drug Pricing Program.

The House Homeland Security Committee held a hearing to examine lessons learned from the 2017 disasters.

Upcoming Committee and Subcommittee Action

March 20 The Senate Judiciary Committee will hold a hearing to examine the reauthorization of the Violence Against Women Act.

The House Education and the Workforce HELP Subcommittee will hold a hearing to examine DOL's proposed rule on association health plans.

The E&C Oversight and Investigations Subcommittee will hold a hearing to examine DEA's role in combating the opioid epidemic.

The Senate Finance Committee will hold a hearing to consider the nominations of John Bartrum to be an Assistant Secretary and Lynn Johnson to be an Assistant Secretary for Family Support, both of HHS.

March 21 The E&C Health Subcommittee will hold a hearing to examine prevention and public health solutions to combat the opioid crisis. Acting Director Dr. Anne Schuchat will testify on behalf of CDC.

The Senate Budget Committee will hold a hearing on the Economic Report of the President.

The Senate Indian Affairs Committee will hold a hearing on the President's FY19 Budget Request for Indian programs.

The House Oversight and Government Reform National Security Subcommittee will hold a hearing to examine bureaucratic challenges to hurricane recovery in Puerto Rico.

The House Ways and Means Health Subcommittee will hold a hearing to examine the implementation of the Medicare Access and CHIP Reauthorization Act's (MACRA) physician payment policies.

March 22 The E&C Health Subcommittee will hold a hearing to examine the opioid crisis as a continuation of the previous day's hearing.

BILL INTRODUCTIONS

March 12 Sen. Dick Durbin (D-IL) introduced S.2535 to strengthen DEA discretion in setting opioid quotas.

Sen. Tina Smith (D-MN) introduced S.2533 to allow National Health Service Corps members to provide obligated service as behavioral and mental health professionals at schools, other community-based settings, or patient homes.

March 13 Rep. Ted Poe (R-TX) introduced H.R.5252 to authorize a grant to protect young athletes from abuse.

Rep. Bill Johnson (R-OH) introduced H.R.5261 to provide for regional centers of excellence in substance use disorder education.

Rep. Peter Welch (D-VT) introduced H.R.5267 to clarify the process for denying, revoking, or suspending a registration to manufacture, distribute, or dispense a controlled substance.

Rep. Ted Budd (R-NC) introduced H.R.5254 to direct the HHS Secretary to conduct a study on the feasibility of expanding eligibility for enrollment in Medicare Advantage plans to individuals enrolled under the Medicaid program or enrolled under a group health plan.

March 14 Rep. Steve Stivers (R-OH) introduced H.R.5272 to ensure that programs and activities that are funded by a grant, cooperative agreement, loan, or loan guarantee from HHS, and whose purpose is to prevent or treat a mental health or substance use disorder, are evidence-based.

Rep. Stephen Lynch (D-MA) introduced H.Res.783 to designate September as National Brain Aneurysm Awareness Month.

Sen. Tina Smith (D-MN) introduced S.2545 to authorize a special behavioral health program for Indians.

March 15 Rep. Marsha Blackburn (R-TN) introduced H.R.5311 to reauthorize and expand the Comprehensive Addiction and Recovery Act (CARA) of 2016.

Rep. Eleanor Holmes Norton (D-DC) introduced H.R.5322 to provide for a national program to conduct and support activities toward the goal of significantly reducing the number of cases of overweight and obesity among individuals in the U.S.

Rep. David Roe (R-TN) introduced H.R.5298 to deem drugs or other substances that act as opioid mu receptor agonists to be in schedule I, subject to exceptions for substances intended for legitimate medical or research use.

Sen. Dianne Feinstein (D-CA) introduced S.2561 to authorize the Attorney General to suspend a controlled substances registration if there is a likelihood of a threat of diversion of a controlled substance.

BRIEFINGS AND CONGRESSIONAL MEETINGS

March 9 Subject Matter Expert(SME) from the National Center for Chronic Disease Prevention and Health Promotion briefed by phone staff to Rep. Michael Burgess (R-TX) and majority staff to the E&C Health Subcommittee on maternal mortality surveillance.

March 12 Acting CDC Director Dr. Anne Schuchat and SME from the Center for Global Health participated in an event on Global Health Security (GHS) in which bipartisan Congressional staff attended. The event was organized by the Kaiser Family Foundation.

March 13 Acting Principal Deputy Director Dr. Stephen Redd participated in a bipartisan Congressional briefing on the second annual inter-agency GHS Agenda report. The briefing was co-sponsored by the Global Health Security Agenda Consortium and PATH.

SMEs from the National Institute for Occupational Safety and Health (NIOSH) participated in a public meeting in Cincinnati on NIOSH's consolidation project. Staff to Sen. Sherrod Brown (D-OH) and Rep. Steve Chabot (R-OH) attended.

March 15 SME from the National Center on Birth Defects and Development Disabilities briefed staff to Rep. Kathy Castor (D-FL) on Zika birth defects surveillance.

March 16 CDCW staff and the Office of Appropriations briefed staff to Sen. David Perdue (R-GA) on proposed funding for a new High Containment Lab at CDC.

CONGRESSIONAL REQUESTS FOR INFORMATION

March 12 Majority staff to the HELP Committeeinquired about appropriations levels of two sections in the Violence Against Women Act.

Staff to Reps. Don Beyer, Jr. (D-VA) and John Katko (R-NY) inquired about the history of CDC's budget as it relates to suicide and the focus of CDC's work in suicide prevention.

Minority staff to the HELP Committee inquired about S.382, the Firefighter Cancer Registry Act of 2017.

March 13 CDCW staff shared information with Senate and House health legislative assistants and staff to the HELP and E&C Committees on the Vital Signs Town Hall Teleconference and Clinician Outreach and Communication Activity Call on opioid overdoses treated in emergency departments.

CDCW staff shared information with staff to the Senate Special Aging Committee, House Congressional Seniors Task Force, and the HELP Primary Health and Retirement Security Subcommittee on the cost of falls specific to senior citizens.

Staff to Rep. Rob Wittman (R-VA) inquired about the process to obtain birth certificates from Puerto Rico.

Staff to Rep. Jim Renacci (R-OH) inquired about a constituent's access to NIOSH publications.

CDCW staff shared information on upcoming NIOSH mobile testing unit visits to Western Kentucky with Sens. Joe Donnelly (D-IN), Tammy Duckworth (D-IL), Dick Durbin (D-IL), Mitch McConnell (R-KY), Rand Paul (R-KY), and Todd Young (R-IN) and Reps. Larry Bucshon (R-IN), James Comer (R-KY), Brett Guthrie R-KY), and John Shimkus (R-IL). The unit offers a series of free, confidential health screenings to coal miners to provide early detection of coal workers' pneumoconiosis (CWP), also known as black lung.

March 14 Minority staff to the Senate Special Aging Committee inquired about the economic impact of diabetes.

CDCW staff shared information with staff to Sen. Bob Casey (D-PA) and Reps. Jim Langevin (D-RI) and Gregg Harper (R-MS) on recently published CDC disability state profiles.

Staff to the Congressional Budget Office inquired about CDC activities related to pediatric cancer.

March 15 CDCW staff shared information with staff to Members interested in tobacco issues and staff to the HELP and E&C Committees on CDC's Morbidity and Mortality Weekly Report on e-cigarettes and youth.

Staff to Sen. Tammy Baldwin (D-WI) inquired about news reports on HIV and syphilis in Milwaukee.

Staff to Rep. Jason Smith (R-MO) inquired about CDC's work in Missouri to address the tick-borne infection, Bourbon virus.

Staff to Rep. Dan Kildee (D-MI) inquired about the Lead Exposure and Prevention Advisory Committee.

March 16 CDCW staff shared information with staff to the Senate Foreign Relations (SFRC) and HELP Committees, the House Foreign Affairs (HFAC) and E&C Committees, and staff to Members of the Florida and Texas delegations on a *New England Journal of Medicine* article on the global threat of Zika virus infection during pregnancy.

CDCW staff shared details with staff to the SFRC and HELP Committees, the HFAC and E&C Committees, and the House Foreign Affairs Western Hemisphere Subcommittee for CDC's media telebriefing on vaccine recommendations for the Yellow Fever outbreak in Brazil.

For questions about this report, please contact
Aimee Schattner at aschattner@cdc.gov or Marissa Thomas at mthomas9@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 15 May 2018 22:48:29 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
Cc: Kegler, Scott R. (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Black, Erin (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Subject: Meeting Notes and Action Item for some
Attachments: Bio Form MMWR JA2949 6.8.18.docx, Suicide VSWG Meeting Notes 5.15.18.docx, State-Level Suicide Trends (Candidate CE Questions).docx
Importance: High

Hi Everyone,
I'm attaching Kristin's notes from our meeting today. Thank you, Kristin!!! (I'm racking up a big debt here!)
Also, per our meeting, I'm forwarding the CE info below. Scott already developed two potential questions for us (Attached here. Thank you, Scott!).
We need two more questions so I was thinking it would be great to have one on the NVDRS analyses and one on the technical package. I will work on these unless someone has a strong desire to take this on.
Regardless of whether you create a question or not, all co-authors have been asked to complete the attached bio form. I wish I could say that it doesn't look time-consuming!
Please send this to me no later than next Wednesday COB (May 23rd).
Thanks, as always let me know if you have any questions or if you have a good question in mind for nvdrs or tp!
Deb

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 15, 2018 2:17 PM
To: Kegler, Scott R. (CDC/ONDIEH/NCIPC)
Subject: FW: Vital Signs - Suicide prevention - June 8, 2018
Importance: High

Thanks for the reminder…

From: Stallworth, Barbara (CDC/OPHSS/CSELS/DPHID)
Sent: Monday, May 14, 2018 10:38 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Stallworth, Barbara (CDC/OPHSS/CSELS/DPHID) <bys5@cdc.gov>
Subject: Vital Signs - Suicide prevention - June 8, 2018
Importance: High

Congratulations! Your MMWR report has been selected for the development of a continuing education (CE) activity.
What we need from you. Please develop 3 CE questions and have all authors listed on the report to complete the attached bio form. Each question will need one correct answer, three incorrect answers, and an explanation. Please return to Barbara Stallworth (bys5) by COB on Friday, **May 25, 2018.**

General Principles:

1) Continuing education (CE) is an opportunity to emphasize the key points of your report to public health and health care professionals. Think about what you want professionals to do or know after they read your report and use those key points to create CE.

2) The question, correct answer, and explanation should be identical or nearly identical to report text. Readers should not have to consult other information sources to answer MMWR CE questions.

Structure of a CE question and answers (see attached guidance for examples):

Question: the question should contain only enough information to orient the reader to the question, and use language adapted from the cleared text.

Correct answer: the reader should be able to correctly answer the question using only information contained in the report.

Wrong answers (3) (distractors): A good distractor should seem like a reasonable answer to someone who didn't read the report carefully. Please do not use "none of the above" or combinations of answer "a and c" as distractors.

Explanation: The explanation should be adapted from cleared text in the report and be brief (no more than 3 or 4 sentences).

Title	MMWR Weekly	Activity #	JA2949	Start date	6.8.18

Division of Scientific Education and Professional Development
Center for Surveillance, Epidemiology and Laboratory Services
Accreditation and Compliance Team
Continuing Education Proposal
Bio/Disclosure Form

Information will be kept confidential. Attach additional pages, if needed.

Date Submitted (mm/dd/yyyy)

Role in Educational Activity (Check all that apply.)
☐ Planner ☐ Faculty/Presenter/Content Expert

Section 1: Demographic Data

Name, credentials,	
Position/title	
Current Employer/address	
Phone	E-mail

Section 2: Education/Expertise

Describe education specific to the educational activity listed above.

Degree	Year	Institution

Describe expertise specific to the educational activity listed above.

Section 3: Conflict of Interest

Federal employees: For the past 12 months, I have been a federal employee and have been covered by all of the federal ethics rules, including the bribery and illegal gratuities statute (18 U.S.C. § 201), the criminal conflict of interests statutes (18 U.S.C. §§ 202-209), and the Standards of Ethical Conduct for Employees of the Executive Branch (5 C.F.R. Part 2635).
☐ Yes ☐ No

Non-federal employees: Is there an actual, potential or perceived conflict of interest for yourself or spouse/partner within the last 12 months?

Title	MMWR Weekly	Activity #	JA2949	Start date	6.8.18

☐ Yes ☐ No

If yes, complete the table below for all actual, potential, or perceived conflicts of interest. Check all that apply.

	Category	Description
☐	Salary	
☐	Royalty	
☐	Stock	
☐	Speaker's Bureau	
☐	Consultant	
☐	Other	

If Planner, Skip sections 4, 5 and 6.

Section 4: Unlabeled use

Will your presentation(s), or the content you contributed, include any discussion of unlabeled use of commercial products or products for investigational use?

☐ Yes ☐ No

If Yes, please explain your use of unlabeled products or products under investigational use. Attach additional pages, if needed.

Section 5: Title of Presentation (Live) OR Content Provided

Section 6: Best Available Knowledge

Is your presentation, or the content you contributed, supported by the best available knowledge or evidence?

☐ Yes ☐ No

Section 7: Statement of Understanding

Completion of the line below serves as the electronic signature of the individual completing this form and attests to the accuracy of the information given above.

Typed Signature: Name and Credentials (Required) Date

FOR DEVELOPERS ONLY:

Indicate mechanism used to resolve real or perceived conflict of interest to be documented in Disclosure Worksheet

☐ Discussion with content expert/presenter ☐ Review of content/presentation

SUICIDE VITAL SIGNS WORK GROUP MEETING

MAY 15, 2018

10A/877-324-1610, (b)(6)
12 noon – 1:00
Note taker: Kristin

Pre-Brief with Dr. Schuchat, Tuesday, May 8th, 1-1:45 ✓

Agenda

- **Set up & welcome** (Deb; **5-10 mins**)
- **Monday's curve ball**
  - **Change from "mental health problems" to "mental health conditions"**
  - **Comms products, FS, and MMWR have all been updated with this language**
    - **Social media, telebriefing script, press release**
    - **Did You Know items will be pulled from the FS**

- **Recap from last week's pre-brief + new updates, next steps**
  - **Pre-brief debrief** (Attendees & Deb; **10 mins**)
  - Next steps (see attached table)
    -

  - **MMWR status** (Deb**; 5 mins)**
  - Next steps (what's on the horizon)
    - Deb rec'd first proof on Friday
      - Revisions were due 8am on Monday – complete
    - Deb rec'd additional reviewer comments from first proof on Monday
      - Revisions submitted on Monday – spoke with Theresa on the phone
    - Deb rec'd second proofs yesterday late in the day
      - Revisions due by 1:00 today
        - Will review the tables again because of concern over double set of proofs
          - A few changes had been made to indentations and bolding of overarching categories
            - E.g., mental health conditions need to be indented
          - Kristin will help with this review
    - Should receive third set of proofs tomorrow
      - Tables need to be reviewed by Friday
      -

  - **Fact Sheet** (Deb; **5 mins)**
  - Next steps
    - Changes to "everyone can" section
    - Changes to page 3 consistent with best practices for media

- Graphic design elements
  - Crystal will coordinate with Molly
- Tom will take first pass and forward to Deb and Kristin

➢ Next version due back to VS team 5/16 COB

➢ **Communication products** (Crystal & Kristin (Q&A); 5 **mins)**

➢ Next steps
- Press release – with VS team
- Critical contacts, dear colleague letter – with VS team
- Social media
  - Pulled directly from FS, but social media team came back with changes
    - Substance abuse – change to "substance use"
    - Will send those to Tom
- Q&A – with Kristin; will send to Deb to review
  - Needs to be submitted to VS team by COB today
- Telebriefing introduction – wording is "Suicide: More than just a MH condition"
- Script – talking points received from Surgeon General yesterday afternoon
  - Need to review – Crystal will send to the group
  - Crystal will put these TPs into the overall script and send the script back out
- Outstanding pieces: Q&A, script, media advisory

➢ **Policy/Partnerships** (Erin; **5 mins)**

➢ Next steps
- Town Hall – June 12
  - Need to identify state examples
    - Colorado should be one
    - Malia can reach out to Ellie at SPRC to get another example
    - Malia will formulate email for Jarrod and Deb will send it
      - The ask will be to do a presentation – need to pull together talking points and slides – we need them by June 1
    - Second state suggestions: NC, MA, TX
      - State health dept seems to be involved
  - Who does this involve?
    - Deb has 8 mins to present, state speakers
    - We can all call in at 2:00 on this day
- Malia has list of partners on board
  - ASTHO CEO will participate in Twitter chat
  - Will take part in NVDRS call to give them a heads up
  - Will talk to DARPI about how to prime CoreSVIPP grantees
  - Congressional plan – hill alerts to every congressional office
    - Hill visits June 7 and 8 – Deb H. and Jim
    - Will do some other Hill visits in September
  - AFSP Policy Summit – June 11
    - Will be there for that briefing (Alex)
  - Erin working with NGA – webinar for policy health advisors in July

- Blog post for national Conference of State Legislators
- Template language for all of our partners – newsletter blurb, customized emails from Jim and Deb for them to send on June 7th – linking VS to priorities

➢ June 7 – press briefing – Deb will be there with Dr. Schuchat

➢ **Other items** (Deb/everyone; **15-20 mins**)
  - ➢ **Town hall**
  - ➢ **Continuing education**
  - ➢ **Science clips**

➢ **Next steps/meeting/Wrap-up** (Deb; **5 mins**)

Next VS Due Dates:

- **To be provided in updates above**



What we need to get moving on ASAP!

- **Town Hall – Need to nail down participant list by end of the week**

Continuing education – candidate questions so people can get CEUs

Comparing just the first and last reporting periods (1999-2001 and 2014-2016) overall suicide rates (both sexes together) were seen to increase in nearly every state. When considering all six reporting periods, what was determined more generally about trends in overall suicide rates at the state level?

☒ Due to excessive fluctuation in rates from one period to the next, for most states nothing conclusive could be determined about general trends.

☑ Most states saw general upward trends that were further determined to be statistically significant.

☒ In most states, rates tended to increase over time, but these trends were not usually found to be statistically significant.

☒ Because some states experienced small numbers of suicides, it was not possible to conduct a comprehensive state-level evaluation of general trends using statistical models.

Explanation: Using data for six consecutive reporting periods covering the years 1999 – 2016, general trends in state-level suicide rates were evaluated using statistical models. For overall suicide rates, statistically significant upward trends were identified for 44 states.

Considering the entire study period, most states saw statistically significant upward trends in overall suicide rates (both sexes together). What was concluded about sex-specific rate trends at the state level?

☒ When stratified by sex, the study data could not support evaluation of rate trends at the state level.

☑ For both males and females considered separately, a majority of states saw statistically significant upward trends in suicide rates.

☒ The upward trends in overall suicide rates were due mostly to increases in rates among males.

☒ In most states, sex-specific rates tended to increase over time, but these trends were not usually found to be statistically significant.

Explanation: Using sex-stratified data for six consecutive reporting periods covering the years 1999 – 2016, trends in sex-specific suicide rates at the state level were evaluated using statistical models. For males, statistically significant upward trends were identified for 34 states. For females, statistically significant upward trends were identified for 43 states.

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 4 Jun 2018 08:50:14 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: NVDRS Talking Points - Use these instead
Attachments: NVDRS Call June 5.docx

Hi Deb – Please use this draft instead of what I sent Friday – there was a typo that I fixed.

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 4:55 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Question

Deb –Here are draft talking points for the NVDRS call on Tuesday. They're high-level overview of the Vital Signs data and logistics.
I think there should be a way to figure out how to share with them verbally the map in the fact sheet – I don't know what that would sound like but maybe you do?
Wanted to get these to you to review – but I think I will tweak on Monday as well.
Malia

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 9:06 AM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Subject: RE: Question

Sounds good. Thanks so much!
Deb

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 9:05 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: Question

I'll pull something together and share with you today. It will basically be: overview of findings, the timeline for release, that they will receive the embargoed copies and when, and what support we might be able give them to help answer questions from their SHOs, media etc.
Let's talk in person on Monday about what else we might be able to share on the phone.
Malia

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 31, 2018 8:07 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Subject: RE: Question

Hi Malia,
I'm happy to join. Would be helpful to have a general outline of what I might want to say. I can then create the talking points from there. Is that possible?
Thanks,
Deb

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 31, 2018 7:38 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Subject: Re: Question

Hi Deb - It is still on, it's June 5 at2pm. do you want to join? since we won't be able to share findings in the 5th I was treating it as a partner call to prime them for the release. It would be great if you have time. It would only be the first 10-15 mind of the call.
Malia

From: "Stone, Deborah (CDC/ONDIEH/NCIPC)" <zaf9@cdc.gov>
Sent: Thursday, May 31, 2018 5:58 PM
To: "Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)" <gdo4@cdc.gov>,"Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)" <jrv8@cdc.gov>
Subject: Question

Hi Shane and Malia,
Is the NVDRS call with states still on to discuss Vital Signs? Do you need me to do this?
Didn't want to lose track of this.
Thanks!
Deb

Deb Stone, ScD, MSW, MPH
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Suicide, Youth Violence & Elder Maltreatment Team
770.488.3942
dstone3@cdc.gov

CDC's Injury Center
Preventing Injuries and Violence Through Science and Action

NVDRS Call – June 5

Talking points

CDC will release a Vital Signs on June 7 that examines rising suicide rates across the United States.

- For this *Vital Signs* report, CDC researchers examined state-level trends in suicide rates from 1999-2016. Additionally, 2015 data from CDC's National Violent Death Reporting System, which covered 27 states, was used to look at the circumstances of suicide among people with and without known mental health problems

- Nearly 45,000 lives lost to suicide in 2016.

- Across the study period, rates increased in all states except for one (which had a consistently high rate throughout). Twenty-five states had suicide rate increases of more than 30 percent.

- More than half of people who died by suicide did not have a known mental health condition.

- The Vital Signs points to ways that states take a comprehensive public health approach to suicide prevention and address the range of factors contributing to suicide.

    - This requires coordination and cooperation among a wide variety of community partners.

    - CDC's technical package on suicide prevention can help states as they make decisions about prevention activities and priorities.

NVDRS Directors will receive an embargoed copy of the Vital Signs at 9am on June 7. State Health Officers will receive this information at 9am as well. As will the media

Vital Signs will be released publically at Noon on June 7 with a telebriefing hosted by Dr. Ann Schuchat, CDC Deputy Director

NCIPC and DVP social media channels will be disseminating information about Vital Signs from June 7-June 19 – including a Twitter Chat on June 11 at 2pm

There will be a Vital Signs Town Hall on June 12 from 2-3pm, which will feature both CDC and state health department speakers

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 21 May 2018 18:01:04 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
Cc: Kegler, Scott R. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC)
Subject: Reminder: Bio Form from all co-authors due Wed COB
Attachments: Vital Signs Candidate CE Questions_19May2018 ds.docx, Bio Form MMWR JA2949 6.8.18.docx
Importance: High

Please complete the attached form by **Wed COB** so that we can have people obtain CE credits for our Vital Signs. Also, attaching our three CE questions. Let me know if you have any concerns or edits.
Thanks!
Deb

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 15, 2018 6:48 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
Cc: Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) ; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Subject: Meeting Notes and Action Item for some
Importance: High

Hi Everyone,
I'm attaching Kristin's notes from our meeting today. Thank you, Kristin!!! (I'm racking up a big debt here!)
Also, per our meeting, I'm forwarding the CE info below. Scott already developed two potential questions for us (Attached here. Thank you, Scott!).
We need two more questions so I was thinking it would be great to have one on the NVDRS analyses and one on the technical package. I will work on these unless someone has a strong desire to take this on.
Regardless of whether you create a question or not, all co-authors have been asked to complete the attached bio form. I wish I could say that it doesn't look time-consuming!
Please send this to me no later than next Wednesday COB (May 23rd).
Thanks, as always let me know if you have any questions or if you have a good question in mind for nvdrs or tp!
Deb

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 15, 2018 2:17 PM
To: Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>
Subject: FW: Vital Signs - Suicide prevention - June 8, 2018
Importance: High

Thanks for the reminder…

From: Stallworth, Barbara (CDC/OPHSS/CSELS/DPHID)
Sent: Monday, May 14, 2018 10:38 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>

Cc: Stallworth, Barbara (CDC/OPHSS/CSELS/DPHID) <bys5@cdc.gov>
Subject: Vital Signs - Suicide prevention - June 8, 2018
Importance: High

Congratulations! Your MMWR report has been selected for the development of a continuing education (CE) activity.

What we need from you. Please develop 3 CE questions and have all authors listed on the report to complete the attached bio form. Each question will need one correct answer, three incorrect answers, and an explanation. Please return to Barbara Stallworth (bys5) by COB on Friday, **May 25, 2018.**

General Principles:

1) Continuing education (CE) is an opportunity to emphasize the key points of your report to public health and health care professionals. Think about what you want professionals to do or know after they read your report and use those key points to create CE.

2) The question, correct answer, and explanation should be identical or nearly identical to report text. Readers should not have to consult other information sources to answer MMWR CE questions.

Structure of a CE question and answers (see attached guidance for examples):

Question: the question should contain only enough information to orient the reader to the question, and use language adapted from the cleared text.

Correct answer: the reader should be able to correctly answer the question using only information contained in the report.

Wrong answers (3) (distractors): A good distractor should seem like a reasonable answer to someone who didn't read the report carefully. Please do not use "none of the above" or combinations of answer "a and c" as distractors.

Explanation: The explanation should be adapted from cleared text in the report and be brief (no more than 3 or 4 sentences).

Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

CE Questions

Question 1. Comparing just the first and last reporting periods (1999-2001 and 2014-2016) overall suicide rates (both sexes together) were seen to increase in nearly every state. When considering all six reporting periods, what was determined more generally about trends in overall suicide rates at the state level?

a Due to excessive fluctuation in rates from one period to the next, for most states nothing conclusive could be determined about general trends.

b Most states saw general upward trends that were further determined to be statistically significant.

c In most states, rates tended to increase over time, but these trends were not usually found to be statistically significant.

d Because some states experienced small numbers of suicides, it was not possible to conduct a comprehensive state-level evaluation of general trends using statistical models.

Explanation: Using data for six consecutive reporting periods covering the years 1999 – 2016, general trends in state-level suicide rates were evaluated using statistical models. For overall suicide rates, statistically significant upward trends were identified for 44 states.

Question 2. What proportion of suicide decedents (in 27 states) in 2015 were *known* to have a mental health condition?

a 54%

b 25%

c 46%

d 75%

Explanation: According to the National Violent Death Reporting System that covered 27 states in 2015, 46% of people were known to have a known mental health condition and 54% were not known to have such a condition.

Which of the following is *not* included as part of a comprehensive approach to suicide prevention, based on the best available evidence?

a strengthening economic supports.

b promoting connectedness.

c creating protective environments.

d public education campaigns.

Explanation: The Centers for Disease Control and Prevention (CDC) published “Preventing Suicide: A Technical Package of Policy, Programs, and Practices. A technical package is a collection of strategies that represent the best available evidence to prevent or reduce public health problems like suicide. The seven strategies in the document are as follows: 1) strengthen economic supports; 2) strengthen access and delivery of suicide care; 3) create protective environments; 4) promote connectedness; 5) teach coping and problem-solving skills; 6) identify and support people at risk; and 7) lessen harms and prevent future risk. At this time, public education campaigns have not been determined to be effective for suicide prevention.

Title	MMWR Weekly	Activity #	JA2949	Start date	6.8.18

Division of Scientific Education and Professional Development
Center for Surveillance, Epidemiology and Laboratory Services
Accreditation and Compliance Team
Continuing Education Proposal
Bio/Disclosure Form

Information will be kept confidential. Attach additional pages, if needed.

Date Submitted (mm/dd/yyyy)

Role in Educational Activity (Check all that apply.)

[ ] Planner [x] Faculty/Presenter/Content Expert

Section 1: Demographic Data

Name, credentials,	
Position/title	
Current Employer/address	Centers for Disease Control and Prevention National Center for Injury Prevention and Control Atlanta, GA
Phone	E-mail

Section 2: Education/Expertise

Describe education specific to the educational activity listed above.

Degree	Year	Institution

Describe expertise specific to the educational activity listed above.

Section 3: Conflict of Interest

Federal employees: For the past 12 months, I have been a federal employee and have been covered by all of the federal ethics rules, including the bribery and illegal gratuities statute (18 U.S.C. § 201), the criminal conflict of interests statutes (18 U.S.C. §§ 202-209), and the Standards of Ethical Conduct for Employees of the Executive Branch (5 C.F.R. Part 2635).

[ ] Yes [ ] No

Non-federal employees: Is there an actual, potential or perceived conflict of interest for yourself or spouse/partner within the last 12 months?

☐ Yes ☐ No

If yes, complete the table below for all actual, potential, or perceived conflicts of interest. Check all that apply.

	Category	Description
☐	Salary	
☐	Royalty	
☐	Stock	
☐	Speaker's Bureau	
☐	Consultant	
☐	Other	

If Planner, Skip sections 4, 5 and 6.

Section 4: Unlabeled use

Will your presentation(s), or the content you contributed, include any discussion of unlabeled use of commercial products or products for investigational use?

☐ Yes ☐ No

If Yes, please explain your use of unlabeled products or products under investigational use. Attach additional pages, if needed.

Section 5: Title of Presentation (Live) OR Content Provided

Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

Section 6: Best Available Knowledge

Is your presentation, or the content you contributed, supported by the best available knowledge or evidence?

☐ Yes ☐ No

Section 7: Statement of Understanding

Completion of the line below serves as the electronic signature of the individual completing this form and attests to the accuracy of the information given above.

Typed Signature: Name and Credentials (Required) | Date

FOR DEVELOPERS ONLY:

Indicate mechanism used to resolve real or perceived conflict of interest to be documented in Disclosure Worksheet

☐ Discussion with content expert/presenter ☐ Review of content/presentation

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 29 May 2018 15:09:37 -0400
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: QS co-release

Hi Rich,
Are the TP's the same as the telebriefing script or the Q's and A's or something different?
-Tom

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Tuesday, May 29, 2018 12:08 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: Fwd: QS co-release

As you see below, the TPs are still under revision.
R

Rich Schieber, MD MPH
CAPT, USPHS

Director, CDC Vital Signs Program
RBS4@cdc.gov
404 697 9666

From: Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>
Date: May 29, 2018 at 11:19:13 AM EDT
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: QS co-release

Thanks. I talked to Dan DeNoon and is working hard on TPs for AS on this.

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Tuesday, May 29, 2018 11:18 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: QS co-release

Tom, I talked again w Charlotte, expressing your points. She and I agree that we will keep the same release date established for both the VS and this QS.
I suggest you write me a terse paragraph about where you want the emphasis to be in the press release and telebriefing (TB). I also suggest you ask her whether she would like to see any modification in either the TB and/or PR, and that you will prepare a Q&A about it. I will send that note up to her. This is a better approach than surprising her on the day of the TB.
I know this is not the outcome you had hoped for, and I'm sorry for that.
Respectfully,
Rich
Rich Schieber, MD MPH
CAPT, USPHS

Director, CDC Vital Signs Program
RBS4@cdc.gov
404 697 9666

From: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Date: May 29, 2018 at 10:18:54 AM EDT
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>, Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: FW:

Hi Rich,

My concern with this QS coming out in the same issue as the VS is that it will put the focus on youth suicides and complicate the messaging. The MMWR focuses on state trends and the range of circumstances that contribute to suicide risk among those with and without mental health conditions. This QS could cause the media to focus on youth suicide. We know that the bulk of suicides are among middle-aged adults. The media however tends to be very interested in youth suicide. We worked with NCHS last year on a QuickStat on youth suicide trends and it ranked number 7 in the 2017 top 10 MMWR reports as measured by Altmetric.

Thank you for considering this.

-Tom

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 29, 2018 9:44 AM
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject:

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 18 Mar 2018 01:21:49 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Jerome

That sounds encouraging (based on Jim's experience) but just a bit confused as we seemed to have gone back to including him in the town hall vs doing the telebriefing (per Erin's email). I don't mind the change, especially if it increases town hall meeting turnout, but will be good to finalize peoples' thoughts on this, e.g. pros and cons of both.
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Saturday, March 17, 2018 11:54 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: FW: Jerome

Hi Deb,
We might not have to limit the SG's comments to military suicide.
-Tom

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 15, 2018 3:54 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: Jerome

Sounds good, although Alex and I saw him present at the Action Alliance meeting yesterday and he was great, by the way. And he spoke to suicide more generally then just vets. He didn't dwell on that and really evoked a lot of our ideas around ACEs and community work. So I wouldn't feel the need to have him focus too much on vets he is quite willing and able to address the issue from a broader perspective.

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 15, 2018 3:24 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>
Subject: RE: Jerome

Yes, as I had mentioned Jim, we are planning to have the SG participate in the townhall. From what Leslie shared based on their experience this would give us the most bang for the buck versus a written commentary from him. As Tom mentioned below, we will plan to include some vet/military stats in his talking points given his interest in vet/military suicides.
I talked to Leslie about the opioid joint COCA/Town Hall and we agree is seems to have gone well. It appeared to have garnered a larger audience (1,197 webinar lines – but participation was likely much higher given many participate via group format). I think it makes sense to do a combined one to save time and effort on coordination, particularly given I am not sure a separate COCA would be as valuable given we are also doing a separate Medscape commentary (similar audience) in which Alex will mention the Vital Signs data but focus on what the physicians, nurses, pharmacists and other healthcare professionals can do specifically to prevent suicide.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, March 14, 2018 1:47 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: Jerome

Hi Jim,
The VS group is thinking that it makes the most sense to engage him in the telebriefing. Deb had suggested that we work through the policy chain to engage him and Erin is going to do that. We met last week and agreed to see how the opioid telebriefing on 3/13 went. We know that he has a particular interest in military suicide. We do provide the proportion of the suicide victims (total and those with and without known mental health problems) who ever served in the military but we don't focus on this. I'm concerned this might not be enough for him to be involved. We could potentially develop some points for him to make about vulnerable groups, including veterans.
Erin what is your take about how the opioid release went and the pros/cons of the SG's involvement? Have you heard from the policy staff who were involved in making this happen?
-Tom

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Wednesday, March 14, 2018 1:27 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: Fwd: Jerome

See below. I spoke with the SG and a couple of his staff today, although not a lot about this. Anything to report yet back on SG communications? I don't think we should reach out about analysis suggestions.

From: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>
Date: March 14, 2018 at 11:27:54 AM EDT
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>
Subject: RE: Jerome
Good! I like him and this is why I thought we should engage him in Vital Signs
Has Tom followed up with his office at all re Jerome's suggestions on analysis or messaging? Didn't know if it was feasible or not

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Wednesday, March 14, 2018 10:17 AM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>
Subject: Jerome
The SG made remarks to the Action Alliance this morning . I was very impressed. He was great - clear that many of his ideas reflect our priorities - ACEs, suicide, Overdose . He was much appreciated by the audience.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 29 May 2018 11:52:29 -0400
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID);Peaker, Brandy (CDC/OPHSS/CSELS/DPHID);Kent, Charlotte (CDC/OPHSS/CSELS/DPHID)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: QS co-release

Hi Rich,
Ok, thank you for considering postponing the QS.
I don't think we want to work the QS findings into the PR or TB. They focus on overall patterns now and we would like to keep that focus. Are you suggesting that I write a paragraph explaining that the QS is coming out in the same issue and make the point about most suicides being among the middle-aged group so that she is prepared and can block and bridge to the main points if the question were to be asked?
Thank you, Tom

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Tuesday, May 29, 2018 11:18 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) ; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Re: QS co-release

Tom, I talked again w Charlotte, expressing your points. She and I agree that we will keep the same release date established for both the VS and this QS.
I suggest you write me a terse paragraph about where you want the emphasis to be in the press release and telebriefing (TB). I also suggest you ask her whether she would like to see any modification in either the TB and/or PR, and that you will prepare a Q&A about it. I will send that note up to her. This is a better approach than surprising her on the day of the TB.
I know this is not the outcome you had hoped for, and I'm sorry for that.
Respectfully,
Rich
Rich Schieber, MD MPH
CAPT, USPHS

Director, CDC Vital Signs Program
RBS4@cdc.gov
404 697 9666

From: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Date: May 29, 2018 at 10:18:54 AM EDT
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>, Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: FW:
Hi Rich,

My concern with this QS coming out in the same issue as the VS is that it will put the focus on youth suicides and complicate the messaging. The MMWR focuses on state trends and the range of circumstances that contribute to suicide risk among those with and without mental health conditions. This QS could cause the media to focus on youth suicide. We know that the bulk of suicides are among middle-aged adults. The media however tends to be very interested in youth suicide. We worked with NCHS last year on a QuickStat on youth suicide trends and it ranked number 7 in the 2017 top 10 MMWR reports as measured by Altmetric.
Thank you for considering this.
-Tom

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 29, 2018 9:44 AM
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject:

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 13:38:04 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Interview Readout

Thank you!! Very appreciative.
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 9:36 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Interview Readout

Hi Deb,
Kristin and I added our responses to what Alex sent. We also added some text on social media to his response for #5.
I'm encouraged by how easy it is to go from our Q's and A's to these responses. They will look familiar to you.
See you soon.
-Tom

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Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
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Thanks so much in advance!
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To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
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Subject: Fw: Vital Signs Interview Readout

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Sent from my BlackBerry 10 smartphone.

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Kate Grusich
Public Affairs Specialist
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(o) 770-488-3337
(c) 404-414-7070

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 09:36:24 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Interview Readout

Greetings:
You are welcome
Alex C

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 9:29 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Interview Readout

Thanks, Alex!!

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Cc: Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Interview Readout
Attachments: QA part2+AC KH and TS.docx

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Q&A Part 2

1) **What's new here? What does this report reveal that's not already out there?**

   This study examines state increases in suicide rates across six consecutive 3-year periods and looks at contributing factors and circumstances to suicide among people with and without a mental health condition in order to understand the broad range of factors that influence suicide.

2) **Was anything in this report particularly surprising to you/CDC?**

   We've known for several years now that suicide rates have been increasing. The current study adds to our understanding by demonstrating that suicide rates increased in nearly all states; and increases of more than 30% were observed in 25 states.

   This study also examined the circumstances that contributed to suicide among decedents and provides new information about the contributing circumstances among those with and without known mental health conditions.

3) **What is CDC trying to achieve by looking more closely at these numbers?**
   The purpose of this study is to understand state suicide rate increases between 1999 and 2016 and to understand the range of contributing factors and circumstances of suicide. Ultimately we want to tell the public that suicide is preventable and that it will take all of us working together to prevent it.

4) **Can you explain why there has been a sustained upswing in the suicide rate in recent years?**
   In Q&A doc—questions on opioids, economy, social media, firearms and their role in increasing rates

5) **Beyond these findings – what is going on in our country? Is today's culture (hate speech, social media, anxiety) driving this trend?**

   Suicidal behavior results from an interaction of multiple factors so there isn't any single reason. There are many current or recent influences that may be affecting suicidal behavior. These include the great recession which increased financial stressors & housing problems, increase in opioid abuse, stigma against help seeking for mental illness, among other changes.

   Changes in social media content or use patterns could also potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

6) **Were you surprised at the number of people who died from suicide who did not have known mental health conditions?**

   We think it is important to point out that among those who are not known to have a mental health condition, we see that they were experiencing a range of other circumstances, including substance misuse, and problems with relationships, their physical health, their job, or financial and legal challenges. Some of these people were also reported to be experiencing depressed mood at the time of their death. This could be related to situational stressors or an undiagnosed mental health condition. It

is possible that mental health conditions could have been present and not known or reported. The results indicate the need for a comprehensive approach to suicide prevention.

7) **Increasing access to mental health has often been cited as key to suicide prevention. How does the finding that many don't have a mental health problem complicate this strategy?**

Access to affordable and effective mental health care is critically important and these results do not change that. Our results suggest that there are also other opportunities to intervene to address the range of circumstances that contribute to suicide risk. These are described in CDC's suicide prevention technical package.

8) **Clinical depression, loneliness, anxiety are all up. Are these factors contributing to the increased rates of suicide?**
In Q&A document

9) **How do you define someone with mental health conditions? Do they have to be diagnosed by a mental health practitioner?**
In Q&A doc

10) **If many of them didn't have a known mental health condition, how do we identify, reach and help them?**
These current results underscore the importance of additional opportunities for prevention, such as
- o teaching coping and problem-solving skills to help people manage life challenges;
- o promoting safe and supportive environments, including safe storage of medications and firearms to reduce access among people at risk for suicide;
- o providing temporary help for people struggling to make ends meet
- o encouraging connectedness so people are less likely to feel alone or isolated.

Everyone can play a role in suicide prevention.
- Physicians and other professionals who work with vulnerable populations (e.g. parole officers, teachers, etc.) have an important role to play in recognizing and appropriately responding to mental health conditions and substance use disorders but also referring people for other types of assistance related to relationship, job, or other stressors.
- Schools can implement evidence-based skill building and other suicide prevention programs
- Employee assistance programs can work to reduce stigma about seeking help and improving access to care.
- Media can follow recommendations to avoid increasing suicide risk end encourage people to seek help
- Everyone can learn the suicide warning signs and the steps to help someone at risk.

11) **Can you provide more insight on why we're seeing increases among (rural areas/Western states/women)?** *In Q&A document*

12) **Do you have more information on veterans and the burden of suicide among this group?**

In Q&A doc

13) **Are medically-assisted suicides included in this report?**
No. Physician-assisted suicide is not included. Only a few states have legalized this and the deaths are not classified as suicides.

14) **Is there a reason why suicide by firearms is higher for people who didn't have a known mental health diagnosis?**
One of the reasons why the proportion of suicides by firearm may be greater among people without a known mental health diagnosis may be because people without a diagnosis were more likely to be male and males are known to use firearms more often in suicide. However, even when controlling for sex, the difference in use of firearms still remained significant among people without a mental health diagnosis which suggests there may be other reasons. Differences in means could also potentially be due to differences in access to specific medications (specific substances are listed in Table 1), however NVDRS does not collect information on access or preference of means so it is not possible to determine how this varied across groups.

15) **Can you describe what "left a note" means in the (MMWR) table. Does that mean one-third of all people who committed suicides left a note? Is that consistent with what's been reported before?**
Yes this is what this means and this is consistent.

16) **What does your prevention strategy look like?**
In Q&A doc re technical package/comprehensive prevention/public health approach

17) **What are the main steps to getting people help early?**

In addition to strategies addressing mental health conditions, the study identified the need for attention to the broader range of circumstances contributing to suicide, including relationship, substance use, physical health, job, financial, and legal problems. For example, we can implement upstream approaches to prevention, such as teaching coping and problem-solving skills to help people manage life challenges; help people stay connected to others for emotional and other types of support and know that other types of assistance are available. For example, employee assistance programs can help connect employees with appropriate assistance for challenges with substance misuse, finances, or relationships. We can all play a role in reducing stigma associated with getting help for mental and other challenges that many people experience throughout their lives.

18) **Do Kate Spade and other high profile suicides make you worry about copycats?**

Research has shown that if high profile suicides are inappropriately covered in the media that they can lead to increases in imitation of suicidal behavior in the population. Recent examples include the suicide of Robin Williams which afterward led to a large increase in calls to the national suicide crisis hotline. Several organizations including CDC worked together to write some recommendation for how the news media could responsively report on suicides and lessen the possibility of imitation. https://afsp.org/wp-content/uploads/2016/01/recommendations.pdf

Other questions that have come up: Please review

Stigma question
Stigma is a real concern. We all could do better to support friends, family, co-workers, and others to seek help without any fear of shame or embarrassment.
Suicide is preventable and help is available, therefore seeking help is a sign of strength.

We need sufficient investment and a comprehensive public health approach. CDC's technical package of comprehensive prevention strategies with the best available evidence provides a range of prevention strategies including creating protective environments so that people are encouraged to get the help they need.

Would you say that suicide is an epidemic?
The increase in suicide rates is undoubtedly a concerning trend that has resulted in suicide prevention being a named priority for the CDC's National Center for Injury Prevention and Control. Much work needs to be done to focus strategies that have been shown to prevent suicide so that we can begin to make an impact at the population level in order to help meet the nation's goal to reduce the annual suicide rate 20 percent by year 2025.

- **If pushed further to specifically call suicide an epidemic, consider stating:**
    - Many aspects of the definition of an epidemic are considered when the CDC identifies a health condition or outcome as an epidemic, including the magnitude of increases observed, the population at risk and the timeframe being considered.
    - We also know that when the media and other entities use language that dramatizes suicide, it can put vulnerable people at risk of self-harm.
    - **That said, we should not downplay the importance of this growing problem, which is why the CDC considers suicide prevention a priority.**
        - The CDC hopes that the findings from this study will help states to understand the magnitude of the problem in their own states, and CDC offers a technical package of policy, programs, and practices with proven effectiveness for preventing suicide as a resource that can help states and communities guide their prevention efforts.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 09:26:38 -0400
To: Crosby, Alexander (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Interview Readout

Kristin and I will merge our responses in what Alex just sent.

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 9:25 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Interview Readout

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Thanks so much in advance!
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To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
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To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>, Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>, Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
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FYI

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Sent: Wednesday, June 6, 2018 6:48 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC); Dorigo, Leslie (CDC/ONDIEH/NCIPC); Sokler, Lynn (CDC/OD/OADC); Harben, Kathy (CDC/OD/OADC); Omisore, Shannon L. (CDC/OD/OADC); Burden, Bernadette (CDC/OD/OADC)
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Kate Grusich
Public Affairs Specialist
CDC News Media Branch
(o) 770-488-3337
(c) 404-414-7070

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Subject: RE: Vital Signs Interview Readout
Attachments: QA part2+AC.docx

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Q&A Part 2

1) **What's new here? What does this report reveal that's not already out there?**

   This study examines state increases in suicide rates across six consecutive 3-year periods and looks at contributing factors and circumstances to suicide among people with and without a mental health condition in order to understand the broad range of factors that influence suicide.

2) **Was anything in this report particularly surprising to you/CDC?**

   We've known for several years now that suicide rates have been increasing. The current study adds to our understanding by demonstrating that suicide rates increased in nearly all states; and increases of more than 30% were observed in 25 states.

   This study also examined the circumstances that contributed to suicide among decedents and provides new information about the contributing circumstances among those with and without known mental health conditions.

3) **What is CDC trying to achieve by looking more closely at these numbers?**
   The purpose of this study is to understand state suicide rate increases between 1999 and 2016 and to understand the range of contributing factors and circumstances of suicide. Ultimately we want to tell the public that suicide is preventable and that it will take all of us working together to prevent it.

4) **Can you explain why there has been a sustained upswing in the suicide rate in recent years?**
   In Q&A doc—questions on opioids, economy, social media, firearms and their role in increasing rates

5) **Beyond these findings – what is going on in our country? Is today's culture (hate speech, social media, anxiety) driving this trend?**

   Suicidal behavior results from an interaction of multiple factors so there isn't any single reason. There are many current or recent influences that may be affecting suicidal behavior. These include the great recession which increased financial stressors & housing problems, increase in opioid abuse, stigma against help seeking for mental illness, among other changes.

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Sent: 7 Jun 2018 13:14:57 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Interview Readout

Thanks, Tom!

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Sent: Thursday, June 7, 2018 8:56 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
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Hi Deb,
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18) Do Kate Spade and other high profile suicides make you worry about copycats?

Kate Grusich
Public Affairs Specialist
CDC News Media Branch
(o) 770-488-3337
(c) 404-414-7070

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 11:19:53 +0000
To: Crosby, Alexander (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Interview Readout
Attachments: Q&A part2.docx

Hi Guys,
Please see attached with the list of questions below.
Would you be willing to divvy up the 6 questions that we don't really address in the Q&As?
Alex, if you could take questions 5&18
Kristin and Tom if you can take 6,7,10, and 17—these questions kind of go together.
Thanks so much in advance!
Deb

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 10:59 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) ; Lane, Gabraelle (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Subject: Re: Vital Signs Interview Readout

Greetings:
Quite an interesting list of questions.
Alex C

From: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>
Date: June 6, 2018 at 6:59:53 PM EDT
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>, Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>, Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>, Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>, Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>, Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: Fw: Vital Signs Interview Readout

FYI

Sent from my BlackBerry 10 smartphone.

From: Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>
Sent: Wednesday, June 6, 2018 6:48 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC); Dorigo, Leslie (CDC/ONDIEH/NCIPC); Sokler, Lynn (CDC/OD/OADC); Harben, Kathy (CDC/OD/OADC); Omisore, Shannon L. (CDC/OD/OADC); Burden, Bernadette (CDC/OD/OADC)

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Q&A Part 2

1) **What's new here? What does this report reveal that's not already out there?**

   This study examines state increases in suicide rates across six consecutive 3-year periods and looks at contributing factors and circumstances to suicide among people with and without a mental health condition in order to understand the broad range of factors that influence suicide.

2) **Was anything in this report particularly surprising to you/CDC?**

   We've known for several years now that suicide rates have been increasing. The current study adds to our understanding by demonstrating that suicide rates increased in nearly all states; and increases of more than 30% were observed in 25 states.

   This study also examined the circumstances that contributed to suicide among decedents and provides new information about the contributing circumstances among those with and without known mental health conditions.

3) **What is CDC trying to achieve by looking more closely at these numbers?**
   The purpose of this study is to understand state suicide rate increases between 1999 and 2016 and to understand the range of contributing factors and circumstances of suicide. Ultimately we want to tell the public that suicide is preventable and that it will take all of us working together to prevent it.

4) **Can you explain why there has been a sustained upswing in the suicide rate in recent years?**
   In Q&A doc—questions on opioids, economy, social media, firearms and their role in increasing rates

5) **Beyond these findings – what is going on in our country? Is today's culture (hate speech, social media, anxiety) driving this trend?**

   Alex

6) **Were you surprised at the number of people who died from suicide who did not have known mental health conditions?**

   Kristin and Tom

7) **Increasing access to mental health has often been cited as key to suicide prevention. How does the finding that many don't have a mental health problem complicate this strategy?**

8) **Clinical depression, loneliness, anxiety are all up. Are these factors contributing to the increased rates of suicide?**
   In Q&A document

9) **How do you define someone with mental health conditions? Do they have to be diagnosed by a mental health practitioner?**
   In Q&A doc

10) **If many of them didn't have a known mental health condition, how do we identify, reach and help them?**
    Kristin and Tom

11) **Can you provide more insight on why we're seeing increases among (rural areas/Western states/women)?** *In Q&A document*

12) Do you have more information on veterans and the burden of suicide among this group?

In Q&A doc

13) Are medically-assisted suicides included in this report?
No. Physician-assisted suicide is not included. Only a few states have legalized this and the deaths are not classified as suicides.

14) Is there a reason why suicide by firearms is higher for people who didn't have a known mental health diagnosis?
One of the reasons why the proportion of suicides by firearm may be greater among people without a known mental health diagnosis may be because people without a diagnosis were more likely to be male and males are known to use firearms more often in suicide. However, even when controlling for sex, the difference in use of firearms still remained significant among people without a mental health diagnosis which suggests there may be other reasons. Differences in means could also potentially be due to differences in access to specific medications (specific substances are listed in Table 1), however NVDRS does not collect information on access or preference of means so it is not possible to determine how this varied across groups.

15) Can you describe what "left a note" means in the (MMWR) table. Does that mean one-third of all people who committed suicides left a note? Is that consistent with what's been reported before?
Yes this is what this means and this is consistent.

16) What does your prevention strategy look like?
In Q&A doc re technical package/comprehensive prevention/public health approach

17) What are the main steps to getting people help early? Kristin and Tom

18) Do Kate Spade and other high profile suicides make you worry about copycats? Alex

Other questions that have come up: Please review

Stigma question
Stigma is a real concern. We all could do better to support friends, family, co-workers, and others to seek help without any fear of shame or embarrassment.
Suicide is preventable and help is available, therefore seeking help is a sign of strength.
We need sufficient investment and a comprehensive public health approach. CDC's technical package of comprehensive prevention strategies with the best available evidence provides a range of prevention strategies including creating protective environments so that people are encouraged to get the help they need.

Would you say that suicide is an epidemic?
The increase in suicide rates is undoubtedly a concerning trend that has resulted in suicide prevention being a named priority for the CDC's National Center for Injury Prevention and Control. Much work needs to be done to focus strategies that have been shown to prevent suicide so that we can begin to make an impact at the population level in order to help meet the nation's goal to reduce the annual suicide rate 20 percent by year 2025.

- **If pushed further to specifically call suicide an epidemic, consider stating:**
  - Many aspects of the definition of an epidemic are considered when the CDC identifies a health condition or outcome as an epidemic, including the magnitude of increases observed, the population at risk and the timeframe being considered.

  - We also know that when the media and other entities use language that dramatizes suicide, it can put vulnerable people at risk of self-harm.

  - **That said, we should not downplay the importance of this growing problem, which is why the CDC considers suicide prevention a priority.**

    - The CDC hopes that the findings from this study will help states to understand the magnitude of the problem in their own states, and CDC offers a technical package of policy, programs, and practices with proven effectiveness for preventing suicide as a resource that can help states and communities guide their prevention efforts.

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: 6 Jun 2018 22:58:51 -0400
To: Lenard, Courtney (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC);Lane, Gabraelle (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
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To: Stone, Deborah (CDC/ONDIEH/NCIPC) , Simon, Thomas (CDC/ONDIEH/NCIPC) , Crosby, Alexander (CDC/ONDIEH/NCIPC) , Holland, Kristin (CDC/ONDIEH/NCIPC)
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(c) 404-414-7070

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 25 Apr 2018 21:09:46 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: 3 more comments--RE: Comm Review--Need your final approval to a few items RE: FOR REVIEW: Vital Signs Communications Products

Hi Deb,
I generally thinks these changes are helpful. Let's see what Leslie says.

(b)(5)

-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 25, 2018 9:51 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: 3 more comments--RE: Comm Review--Need your final approval to a few items RE: FOR REVIEW: Vital Signs Communications Products

Hi Tom,
I'm glad you liked the suggested text from last night's email. I got tired and didn't include these three final edits that are also in the materials Leslie is reviewing. Let me know whether you are ok with these. Thanks!

1. **Re your comment (Consider adding a bullet that drives home the point in the MMWR** about how suicide prevention is often oriented towards downstream identification of suicidal people, treatment of MHP and prevention of reattempts. Additional focus on non-mental health factors, further upstream, is important for a public health approach (10).

   (b)(5)

   (b)(5)

2. **Re recommendations section:** I suggest connecting the dots between the results and prevention messages more explicitly –like you do in the discussion of the MMWR. Mental health is clearly important and we need…The results also show that many other circumstances contribute to risk among those with and without mental health problems and we need upstream approaches to prevention…

   (b)(5)

   (b)(5) the study identified a need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to providers in underserved areas is needed, as is expansion of healthcare systems needed that integrates physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions.
   In addition to strategies addressing mental health problems, (b)(5)

   (b)(5)

   Together a comprehensive approach to suicide includes: [insert 7 strategies]

3. **Re comment in key findings section—(It would be good to add some text here or below from the MMWR conclusion that connects these results back to the need for broader prevention and the TP.)**
   More than half of suicide decedents in NVDRS did *not* have a known mental health problem. This group suffered more from relationship problems and other life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises, however such circumstances were also common in people with mental health problems. To address the full range of contributing factors to suicide, comprehensive suicide prevention activities are needed. Such strategies include both upstream prevention to prevent risk from occurring in the first place as well as more downstream activities responsive to the needs of people at increased risk and to prevent re-attempts. The CDC's technical package to prevent suicide provides such a broad approach.

Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 25, 2018 8:56 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: Comm Review--Need your final approval to a few items RE: FOR REVIEW: Vital Signs Communications Products

Hi Deb,
I like these changes. Thank you for being so thoughtful about these documents.
-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, April 24, 2018 8:38 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: Comm Review--Need your final approval to a few items RE: FOR REVIEW: Vital Signs Communications Products
Importance: High

Hi Tom,
Are you ok with these edits to the telebriefing script (changes from original text in red) and the press release (4th item)? The second one highlighted below would mean a change to the factsheet as well.

- Suggested change: People who died by suicide and who did not have a known mental health problem, were more likely than those *with* a mental health problem to struggle with **relationship problems or loss** (45% vs 40%), any **life stressors** (54% vs 50%), and **recent or impending crises** (32.9% vs 26.0%). However, and importantly, these circumstances were common to both groups.
  - Original: People who died from suicides and did not have a known mental health problem, were more likely to struggle with **relationship problems or loss** (45.1% vs 39.6%), **life stressors** (54.2% vs 49.7%), and **recent/impending crises** (32.9% vs 26.0%), however, and importantly, these circumstances were common across those with and without known mental health problems.
    - Rationale: Since I'll be giving the percentages (x% vs y%), it seemed better to let people know the Y group is sooner rather than later, especially since we haven't referred to them previously at this point. The change also reduces the number of words which should make interpretation clearer.

- Suggested change: On a Federal level, government agencies are tracking the problem of suicide and suicide attempts to understand trends and groups at greatest risk. They are developing, implementing and evaluating suicide prevention strategies in communities and working with (b)(5)
    - Original: On a Federal level, government agencies are tracking the problem of suicide and suicide attempts to understand trends and groups at greatest risk. They are developing, implementing and evaluating suicide prevention strategies in communities and working with local, state, tribal and other partners to prevent suicide.
        - Rationale: The new version gives a nod to the National Action Alliance and it avoids having the second and third ideas (dev, impl, eval prevention, and preventing suicide) be so closely linked in meaning. It also of course mentions the national strategy which is good I think (even if we are focused on state suicide prevention).
- Suggested change: The bottom line is that many factors contribute to suicide so it will take a coordinated and comprehensive response to prevent it. And everyone has a role.
    - Original: The bottom line is that it will take a coordinated and comprehensive response to prevent suicide, and everyone has a role.
        - Rationale: I thought we should weave back in the idea of multiple factors more directly.
- Suggested change: States can use *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* to (b)(5)
    - Original: States can use *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* to guide actions based on what is known about keeping people safe.
        - Rationale: I think there's a point of diminishing returns when it comes to plain language. Also, keeping people safe (b)(5) (b)(5)

Press Release: Added this to the press release at the end (the part that you said was too fluffy. Note that I changed the wording a little related to the sectors. See what you think. It's very common for the field to refer to the private sector and this way we can easily fold in the media.

- "Close communication and coordination of activities between the public health sector and other sectors such as health care, mental health, social services, law enforcement, education, faith, (b)(5) is critical. To inform states and communities' decision-making about prevention priorities, the CDC released a technical package for suicide prevention that describes strategies and approaches based on the best available evidence."

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Tuesday, April 24, 2018 5:23 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Subject: RE: FOR REVIEW: Vital Signs Communications Products

Hi Crystal,

I have some comments in each. I discussed them with Deb and I'm ccing her on this email so that she can start working on them so that you can meet the goal of sharing these with Leslie tomorrow. I told Deb that we might have more time on the Q&A but she is going to start to answer the questions I added and pull in some more examples from existing Q&A. This way we will have them if we need to send on Friday and Leslie can see them too.
Thank you, Tom

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Tuesday, April 24, 2018 8:22 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Subject: FOR REVIEW: Vital Signs Communications Products
Importance: High

Hi Tom,
We are moving right along with clearance of the VS communication products, and you are up next! You will see a tracker at the top, so when you have completed your review, please note it there and return them to me with your edits; I'll see that they get to the next reviewer. Each reviewer has one day.
Thanks in advance!
Respectfully,

Crystal Bruce, MPH
Health Communications Specialist
Detailed to National Center of Injury Prevention and Control
Division of Violence Prevention, Health Communications Team
Office: 770-488-5651
Mobile: 470-249-3616
Cbruce2@cdc.gov
Off alternate Fridays

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 18 Jul 2018 16:17:02 -0400
To: Holland, Kristin (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: A few more to approach summaries to review

Wonderful! I'll make that change and the ones suggested by Deb. Thank you both for your quick review!!

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: Wednesday, July 18, 2018 4:14 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: A few more to approach summaries to review

These are all great. I reviewed these and the other ones, and the attached is the only one I had a small comment on. Nothing major. Everyone did a great job on these.
Kristin

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, July 17, 2018 7:43 PM
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: A few more to approach summaries to review

Here you go! Thanks, Linda! These all looked great!
Deb

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, July 16, 2018 9:16 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: A few more to approach summaries to review

Hello –
Here are two more summaries to review over the next few days. For all of these, no need to do a thorough review – just a quick scan to make sure there are no glaring mistakes or things missing that should definitely be included.
Let me know if you have any questions. Thanks for your help!
Linda

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Friday, July 13, 2018 3:07 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: For Review by COB 8/17: suicide approach summaries for the implementation guidance

Hello,
We are in the home stretch of completing the implementation guidance for the TP's. One component of the guidance pertains to the specific approaches in the technical packages. We are down to the last 8 summaries – 7 of them are specific to the suicide TP. We put these on hold until after the Vital Signs – for obvious reasons!
Attached are 3 short ones for your review.
Lindsey is hoping to get this last batch into clearance ASAP – we are up against a contract deadline with Banyan. If you could review and send any comments/suggestions on the three attached by Tuesday COB, I'll incorporate your changes and get them ready for clearance.
The other ones that we need to finalize include:

- Postvention
- Safer suicide care through system change
- Treatment for people at risk of suicide
- Treatment for victims/survivors (which includes content across the technical packages)

Please let me know if you have any questions.
Thanks in advance for your help!
Linda

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: 18 Jul 2018 16:14:29 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: A few more to approach summaries to review
Attachments: SUI_Gatekeeper Training - for SME review ds kh.docx

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From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Friday, July 13, 2018 3:07 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: For Review by COB 8/17: suicide approach summaries for the implementation guidance
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Gatekeeper Training

This approach focuses on training individuals such as teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others in the community to identify and respond effectively to people who may be at risk of suicide. By identifying people at risk of suicide and linking them to appropriate support and care, gatekeeper training can positively impact suicide and risk factors for suicide such as depression and feelings of hopelessness.

Strategy

- **Identify and Support People at Risk** (Suicide)

Key Objectives	• Improve ability of gatekeepers to identify and understand the warning signs of suicide • Learn how to intervene appropriately and help people at risk of suicide • Increase knowledge of available resources and support
Implementation Considerations	• Programs may be implemented in a variety of settings (e.g., schools, university/campus, healthcare, community, military) • Many programs include specific guidance for the nature and sequencing of content to help gatekeepers feel comfortable with recognizing and inquiring about risk and facilitating access to support and care • Programs are often delivered in groups and use a combination of methods (e.g., group discussion, audiovisual learning aids, presentations, role-playing) to provide opportunities to engage participants and practice skills • Training requirements vary depending on specific program model, ranging from a few hours to 2-5 days • Evidence of effectiveness also varies for different programs, so it is important to review the evidence supporting a specific program before selecting one to implement
Sector Engagement	• Public health • Healthcare • Education • Government • Community organizations
Example Outcomes	• Reductions in ○ suicide ~~deaths~~ ○ suicide attempts ○ depression ○ feelings of hopelessness
Additional Resources	• Comparison Table of Suicide Prevention Gatekeeper Training Programs (Suicide Prevention Resource Center) http://www.sprc.org/sites/default/files/migrate/library/SPRC_Gatekeeper_matrix_Jul2013update.pdf

Example Programs/Practices/Policies:

- Applied Suicide Intervention Skills Training (Suicide)
- Garrett Lee Smith Suicide Prevention Program (Suicide)

Comment [HK(]: Could add 'access care' at the end here so it's clear the people identifying aren't the ones who have to provide care.

Comment [zaf9]: Could drop this phrase. It's a little confusing.

Comment [HK(]: Agreed – it's not clear.

Comment [zaf9]: Maybe say from a few hours to 1 or more days?

Example Programs

Applied Suicide Intervention Skills Training (ASIST) (Suicide)

Description: ASIST is a training program for hotline counselors, emergency workers, clergy, caregivers and others in the community. The ASIST model has three phases of caregiving: connecting, understanding and assisting. In the first phase (connecting), participants learn how to identify people who are having thoughts of suicide. In the second phase (understanding), participants learn how to recognize the caller's invitation for help and how to listen to the caller's reasons for dying and living. In the third phase (assisting), participants learn how to conduct a safety assessment, develop a safety plan for the person at risk, and connect the person at risk to community resources. The ASIST training program has been field tested in a variety of settings.

Specific Populations/Settings	Key Partners	Considerations
• Population(s): Persons at risk of suicide • Setting(s): School, community, military	• Community organizations • Healthcare providers • Emergency medical services • Faith-based organizations • Government (local, state, federal) • School administrators and staff • Public health agencies	• 2-day training workshops are required to deliver the ASIST program • Materials and consultation support are available • Program cost available online

Additional Information

- ASIST Program Site - https://www.livingworks.net/programs/asist/
- Program Summary (SPRC) - http://www.sprc.org/resources-programs/applied-suicide-intervention-skills-training-asist

Garrett Lee Smith (GLS) Suicide Prevention Program (Suicide)

Description: Gatekeeper training is a core component of the Garrett Lee Smith (GLS) Suicide Prevention Program which has been implemented in states, territories, tribal communities, and college campuses across the United States. The program is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Individuals are trained to better recognize the risk for suicide, inquire about risk, intervene appropriately, and help the suicidal individual obtain assistance. Training ranges from a few hours to a few days.

Populations/Settings	Key Partners	Considerations
• Population(s): Persons at risk of suicide • Setting(s): School/college campuses, community	• Community organizations • School/campus administrators and staff • State mental health agencies • Government (local, state, federal) • Tribal communities • Public health agencies	To find the state or local GLS grantees in your community visit this website.

Additional Information

- SAMSHA – Garrett Lee Smith Suicide Prevention Program – http://www.samsha.gov

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 17 Jul 2018 21:15:29 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: A few more to approach summaries to review

Thank you!

Appreciate your quick review!

From: "Stone, Deborah (CDC/ONDIEH/NCIPC)"
Sent: Tuesday, July 17, 2018 7:43 PM
To: "Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)" ,"Holland, Kristin (CDC/ONDIEH/NCIPC)"
Subject: RE: A few more to approach summaries to review

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From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Monday, July 16, 2018 9:16 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
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Sent: 17 Jul 2018 23:43:25 +0000
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: A few more to approach summaries to review
Attachments: SUI_Safe Reporting and Messaging About Suicide - for SME review ds.docx, SUI_Postvention - for SME review ds.docx

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Safe Reporting and Messaging About Suicide

The manner in which information on a recent suicide is communicated to the public can heighten the risk of suicide among vulnerable individuals and can inadvertently contribute to suicide contagion. This approach promotes prevention messaging and reporting on suicide in a way that reduces the possibility of suicide contagion, encourages help-seeking, and promotes evidence-based actions that can help prevent suicide.

Strategy

- **Lessen Harms and Prevent Future Risk** (Suicide)

Key Objectives	• Increase awareness and adherence to guidelines for reporting on suicide • Reduce the likelihood of suicide contagion • Promote positive prevention messages
Implementation Considerations	• Present accurate information about suicide rates and trends • Use suicide prevention experts to provide accurate information on suicide risk factors, warning signs, and prevention • Avoid sensationalizing suicide or referring to suicide as "successful" or "unsuccessful" or a "failed attempt" • Avoid conveying details around the method used in the suicide • Provide information in a way that avoids attributing suicide to a single cause • Incorporate prevention messages and actions that can help prevent suicide • Promote evidence-based solutions and prevention success stories • Use stories of hope and resilience • Encourage help-seeking by Incorporating information on local resources and support
Sector Engagement	• Public health • Media • Education • Government • Community organizations
Example Outcomes	• Reductions in ○ rates of suicide ○ contagion effects related to suicide • Increases in protective factors • Improvements in reporting following suicide
Additional Resources	• Recommendations for Reporting on Suicide - http://reportingonsuicide.org/ • Suicide Prevention Resource Center - http://www.sprc.org/keys-success/safe-messaging-reporting

Comment [zaf9]: This seems a little circular. Isn't what this whole thing is about how to improve reporting to prevent suicide?

Postvention

Postvention approaches are implemented after a suicide has taken place and are intended to provide bereavement support for surviving family members, friends, and other close contacts. Postvention includes debriefing sessions, counseling, support groups, and other activities to facilitate healing. People who have lost a friend/peer, family member, co-worker or someone else close to them to suicide are at increased risk for suicide. Care and attention to the bereaved is important for helping reduce this risk.

Strategy

- **Lessen Harms and Prevent Future Risk** (Suicide)

Key Objectives	• Facilitate healing and promote healthy recovery of individuals, families, and communities bereaved by suicide • Prevent suicide among surviving friends, family, and/or community members
Implementation Considerations	• Postvention may be delivered in a variety of settings (e.g., schools, workplaces, community) • Procedures for responding effectively to suicide and connecting survivors to community services and resources should be developed and in place prior to a death by suicide • A multidisciplinary team comprised of mental health professionals, people who have previous experience surviving a suicide loss, and others involved in crisis response activities can help ensure resources are appropriately identified and in place to support survivors • Postvention plans should be flexible to address a variety of circumstances and take into account both shorter- and longer-term needs
Sector Engagement	• Public health • Education • Business and Labor • Healthcare • Government • Community organizations
Example Outcomes	• Reductions in ○ survivors' guilt, feelings of depression, and distress ○ contagion effects related to suicide ○ suicide attempts ○ suicidal ideation
Additional Resources	• Postvention (Suicide Prevention Resource Center) - http://www.sprc.org/comprehensive-approach/postvention • Postvention for College Campuses (Higher Education Mental Health Alliance) - http://hemha.org/postvention_guide.pdf • Postvention Guide – Alaska Suicide Prevention Plan - http://dhss.alaska.gov/dbh/Documents/Prevention/docs/POSTVENTION%20GUIDE%20V5.pdf

Example Programs/Practices/Policies:

- StandBy Response Service (Suicide)

Comment [zaf9]: This one looks ok, but here are the more usual suspects: From the Action Alliance--Survivors of Suicide Loss Task Force. (2015, April). *Responding to grief, trauma, and distress after a suicide: U.S. National Guidelines* (p. 1). Washington, DC: National Action Alliance for Suicide Prevention. Retrieved from http://actionallianceforsuicideprevention.org/sites/actionallianceforsui...

And http://www.sprc.org/comprehensive-approach/postvention

Example Programs

StandBy Response Service (Suicide)

Description: StandBy Response Service is a suicide bereavement support service. The service provides clients with face-to-face outreach and telephone support provided by a professional crisis response team. A site coordinator then develops a customized case management plan, referring clients to other existing community services matched to their needs. The program also includes community education and activities with local community groups, businesses, and other organizations.

Specific Populations/Settings	Key Partners	Considerations
• Population(s): Persons bereaved by a recent or past suicide • Setting(s): Community	• Health care • Mental health providers • Community organizations • Public health agencies	• Services are available 24/7 and may be delivered in-person or by phone • Consultation and support is available to coordinators at Standby Response sites • Program cost information is not available

Additional Information

- StandBy Support After Suicide Program Site - http://standbysupport.com.au/

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 9 Mar 2018 21:26:14 +0000
To: Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: Abstract for MHWG Meeting

Thanks, Crystal. This looks great! I added a few more goals of the Vital Signs and will add a few other talking points on the TP summary slide but I can manage that.
I really appreciate your support on everything!!
Have a great weekend!
Deb

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Friday, March 9, 2018 11:22 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Abstract for MHWG Meeting

Hi Deb,
Here's a first draft of the presentation for the MHWG; let me know your thoughts and I'm happy to revise. ☺
Crystal

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 8, 2018 4:45 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: RE: Abstract for MHWG Meeting

Thank you so much. I really appreciate the help, Crystal. I will try not to bother you tomorrow on your flex day!!
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I wonder if it would be good to put a slide in the beginning to let people know that the VS stuff is part and parcel of this presentation.
Maybe even change the title to reflect that? Not sure how much we can say though so I'll leave that up to you.
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Thanks for your help!

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Sent: Wednesday, March 7, 2018 6:03 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: FW: Abstract for MHWG Meeting

Hi Crystal,
Hope you are doing well and have water! Just got this. Should we also insert the vital signs piece before or after the technical package?
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From: Khalil, George M. (CDC/OID/NCHHSTP)
Sent: Wednesday, March 7, 2018 8:15 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Merrick, Melissa T. (CDC/ONDIEH/NCIPC) <kcq7@cdc.gov>; Holbrook, Joseph (CDC/ONDIEH/NCBDDD) <vzt4@cdc.gov>; Lutfy, Caitlyn (CDC/OPHPR/DEO) <vxa3@cdc.gov>
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- **Suicide Prevention: Technical Package**

Dr. Deb Stone, ScD, MSW, MPH
Behavioral Scientist, ONDIEH

Abstract:
To improve program practice across the U.S., a group of scientists led by Dr. Stone from the Division of Violence Prevention (DVP) and the Division of Analysis, Research and Practice Integration (DARPI) developed a technical package of policies, programs and practices for the prevention of suicide. Published in 2017, the technical package provides a core set of strategies to achieve and sustain substantial reductions in self-directed violence based upon the best available evidence.

Please make revisions as you see fit. I'd like to send this out to the workgroup ASAP.
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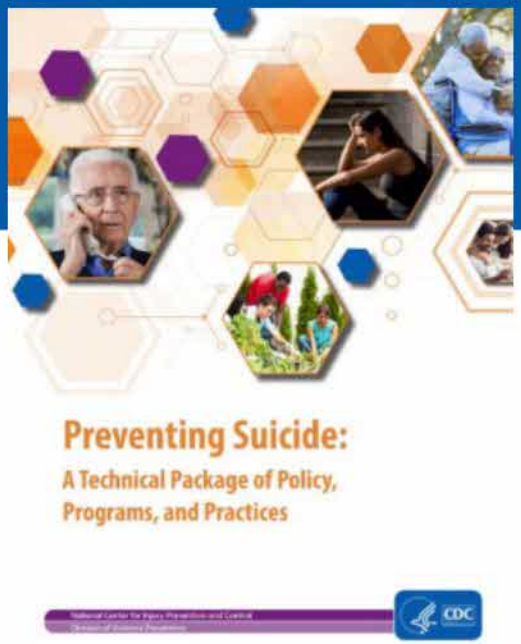
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Suicide Prevention: Technical Package & *New* Vital Signs



CDC Vitalsigns™

Division of Violence PreventionNational Center for Injury Prevention and ControlCenters for Disease Control and Prevention Deb Stone, ScD, MSW, MPH

Serious Public Health Problem

- Suicide accounts for more than 44,000 deaths each yearRates of suicide are rising in the U.S. Leading cause of death across the lifespanHigh burden in multiple population groupsMany more people hospitalized or treated in ambulatory settings for nonfatal suicidal behavior than die



Suicide is Preventable



- Connected to other forms of violenceShares common risk factorsRequires a comprehensive approach targeting multiple risk and protective factors across the social ecology

Benefits of a Technical Package

- Technical packages: one of the six key components for effective public health program implementation Sharpen and focus what otherwise might be vague commitments to "action"
  Avoid a scattershot approach of a large number of interventions, many of which have only a small impactAchieve substantial and synergistic improvement in outcomes

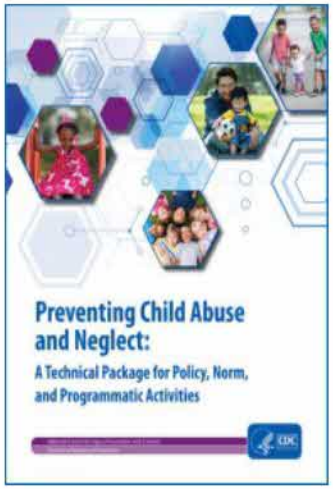


Suicide Technical Package

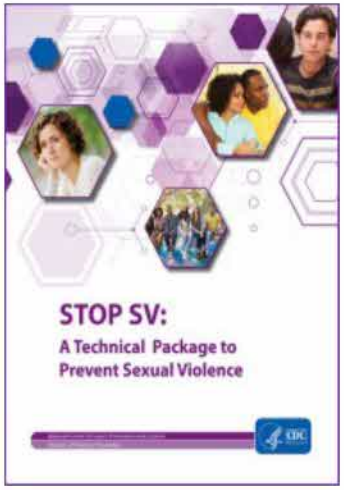


Select group of strategies based on the best available evidence to help communities and states sharpen their focus on priorities with the greatest potential to prevent suicide.

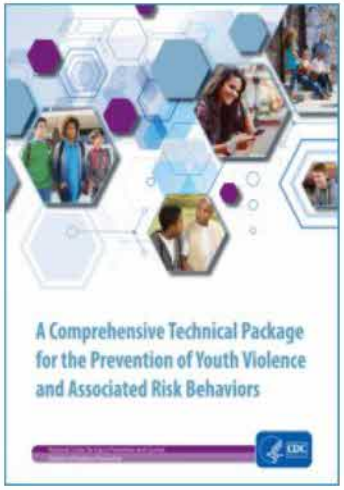
Helping States and Communities Take Advantage of the Best Available Evidence



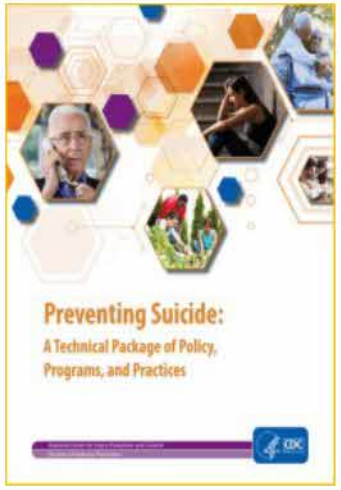
2016



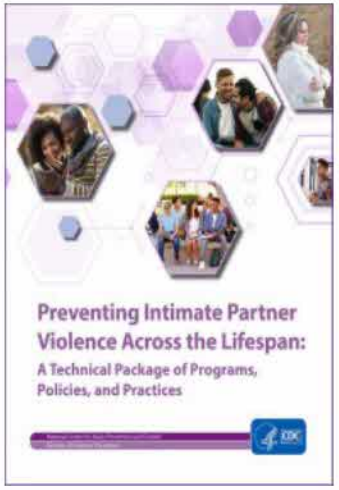
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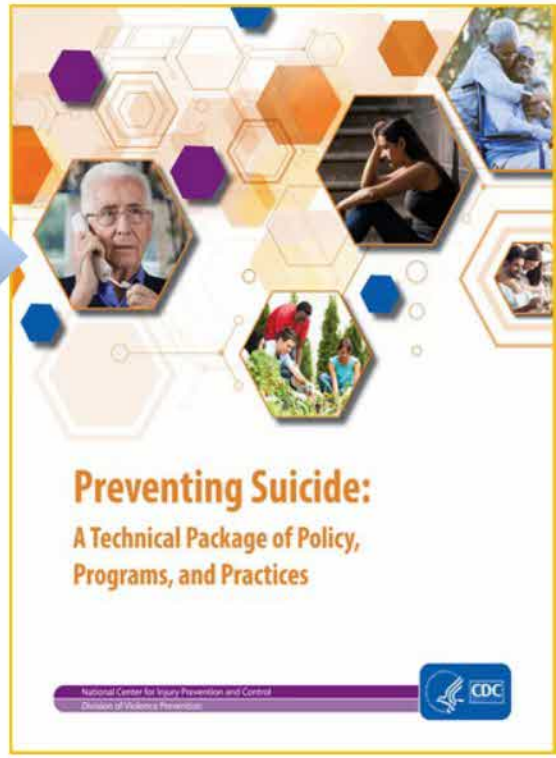
2017

Structure

Three components:Strategy – direction or action Approaches – specific ways to advance the strategy (examples: programs; policies; practices)Evidence – for each approach in preventing violence or impacting risk and protective factors

Technical Package Development





Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., & Wilkins, N. (2017). *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Considerations for Inclusion

- Example programs, policies, and practices selected based on the best available evidence:Meta-analyses, systematic reviews, rigorous evaluation studies showing impacts on suicide/suicide attempt outcomes or risk/protective factorsBeneficial effects on multiple forms of violenceSimilar outcomes with different settings/populations Feasibility of implementation in U.S. if evaluated in another countryNo evidence of harmful effects on specific outcomes or with subgroups

Summary Table

Strategy	Approach
Strengthen economic supports	▪ Strengthen household financial securityHousing stabilization policies
Strengthen access and delivery of suicide care	▪ Coverage of mental health conditions in health insurance policiesReduce provider shortages in underserved areasSafer suicide care through systems change
Create protective environments	▪ Reduce access to lethal means among persons at risk of suicideOrganizational policies and cultureCommunity-based policies to reduce excessive alcohol use
Promote connectedness	▪ Peer norm programs Community engagement activities
Teach coping and problem-solving skills	▪ Social-emotional learning programsParenting skill and family relationship programs
Identify and support people at risk	▪ Gatekeeper trainingCrisis interventionTreatment for people at risk of suicideTreatment to prevent re-attempts
Lessen harms and prevent future risk	▪ PostventionSafe reporting and messaging about suicide

Sector Involvement

- Public healthEducationGovernment (local, state, federal)Social servicesBusiness/laborHealth servicesJusticeHousingMedia Military and Veteran organizationsFaith-base other non-governmenta organizations



Monitoring and Evaluation

- Timely and reliable dataMonitor extent of problem & evaluate impact of prevention effortsProgram planning, implementation and assessment



What's Next?



CDC Vitalsigns™

Goals of the Report

- Report trends in rates in the U.S. and by state and sex. Summarize suicide circumstances using the 2015 NVDRS. Compare suicide risk factors among people with and without mental health problems

Activities

- Emails from leadershipGovDeliveryTelebriefing – CDC Director CDC Washington – emails to key congressional offices promoting Vital SignsOSTLTS Town HallOSTLTS Did You Know – three factoids raising awareness about suicideNIH/NIMH webinar – to promote Vital Signs to researchers and MH practitioners ASTHO All SHO Call – to promote Vital Signs and technical package to State Health OfficersMedscape Video Commentary

Summary



Questions



For more information

Visit CDC's page on the technical packageshttps://www.cdc.gov/violenceprevention/pub/technical-packages.html and other violence prevention pageswww.cdc.gov/violenceprevention



NCIPC OC Clearance:
DVP ADS Clearance:
DVP Policy Review: Malia Richmond-Crum, Heather Dennehy 7/26/18
DVP HCET Review: Erin Black, 7/24/18
DVP SME Review: Deb Stone 7/23/18

ASTHO Suicide Podcast

Questions for CDC guest

Your Vital Signs report tracks suicide rates over an 18-year ~~ten-year~~ period, 19996-2016, and finds that suicide is on the rise. What's happening?

- **Suicide is a public health problem.**
  - Nearly 45,000 lives were lost to suicide in 2016, which is approximately one suicide every 12 minutes.
  - Suicide and nonfatal self-harm injuries cost more than $69 billion annually in direct medical and work loss costs.
  -
  - Rates have increased by nearly 30% from 1999-2016 (28.1%)Suicide is one of just three leading causes of death that are on the rise.
  - In the recent Vital Signs, we found that suicide rates increased in nearly every state across the nation.
  - 25 states had increases greater than 30%.
    ~~Rates have increased by nearly 30% from 1999-2016 (28.1%)~~
  -
  - ~~Suicide rates vary by race/ethnicity, age, and other population characteristics, with the highest rates across the lifespan occurring among non-Hispanic American Indian/Alaska Native (AI/AN) and non-Hispanic White population groups, middle-aged adults, veterans and active duty personnel, certain occupational groups, and sexual minority youth.~~
  - ~~More than half of suicide deaths occur among adults in the prime of their lives, ages 35-64.~~
  - ~~Suicide rates in rural areas are consistently higher than rates in more urban areas.~~
  - Suicide and nonfatal self-harm injuries cost more than $69 billion annually in direct medical and work loss costs.

While the Vital Statistics data are great for describing trends they don't tell us about the causal factors that are driving the increases.

Comment [ST(]: I don't understand why this was written like this. The period of the MMWR was 1999-2016 and this is 18 years not 10.

Comment [ST(]: I'm requesting edits here to provide the VS results.

Comment [ST(]: I would keep this simple and more focused on what is in the VS.

We do know that suicide is not caused by any one factor, but instead, it is typically caused by a combination of individual, relationship, community, and societal factors.

To better understand the circumstances that contributed to suicide we looked at NVDRS data from 17 states. We found that more than half of people who died by suicide did not have a known mental health condition. M~~highlighted in our past Vital Signs m~~any ~~other~~ factors ~~that~~ contribute to suicide among those with and without a mental health condition, including :

- 42% relationship problems
- 29% crisis in the past or upcoming two weeks
- 28% problematic substance abuse
- 22% physical health problem
- 16% job/financial problem
- 9% legal problem
- 4% loss of housing

Several factors ~~Several such factors~~ could be contributing to the increases:

Economic conditions
The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability could have contributed to increases in suicide risk. Past research on the association between business cycles and U.S. suicide rates indicates that the overall suicide rate rises and falls in connection with the economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.

Opioid epidemic
When there is an increased availability and misuse of prescription opioids, we may see increases in suicide rates. Substance misuse itself is an established risk factor for suicide and, therefore, opioid misuse associated with the opioid overdose epidemic could be driving the suicide rate higher. When we look at who is dying from suicide and who is dying from unintentional overdoses involving opioids, we see that there is overlap in the demographics of the populations most highly affected by suicide and unintended opioid overdose deaths.

Social media
More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is

needed to determine how to reduce risk and enhance the protective factors associated with social media.

Rural

While there have been increases and decreases in suicide rates over time, research shows that rates across cities and towns in the United States have been rising, with rural areas experiencing the most increases. The increased rates may be associated with suicide risk factors that are more common in less urban areas, such as limited access to mental healthcare as well as greater social isolation.

Let's explore the factors that can play into a person's decision to take his or her own life. What are they?

Many people think that suicide is an unexplainable act, when, in reality, many known factors increase risk ~~across the individual, relationship, community, and societal~~ levels.

These include:

- History of previous suicide attempts
- Family history of suicide
- History of child abuse and neglect or other adverse childhood experiences
- History of depression or other mental illness
- Alcohol or drug abuse
- Feelings of hopelessness or isolation
- Impulsive or aggressive tendencies
- Stressful life event or loss (e.g. relationship, job, money, criminal/legal problems)
- Easy access to lethal methods
- Exposure to the suicidal behavior of others
- Isolation, lack of social connectedness

The presence of any one of these factors does not mean someone is thinking about suicide or will attempt suicide. Researchers agree that suicidal behavior results from an *interaction* of factors and is rarely due to a single cause.

How do I know if someone is at high risk of making a suicide attempt?

The warning signs for suicide are:

- Expressing hopelessness
- Increased anger or rage
- Extreme mood swings
- Sleeping too little or too much
- Making plans for suicide
- Talking and/or posting about wanting to die~~suicide~~
- Feeling trapped or in unbearable pain
- Increased anxiety

Comment [ST(]: I don't think you need to complicate the list with this.

- Securing lethal means
- Increased substance use
- Feeling like a burden
- Isolation

If you notice any of these signs:

- **Ask** the question, "Are you thinking about suicide?" Asking the question won't make someone suicidal, and instead, may relieve or reduce the feeling.
- If the person says yes, **keep** them safe. Find out if they have a suicide plan. Remove any lethal means in the environment, if possible, and do not leave the person alone.
- **Be there** and show concern. Don't act surprised or dismiss their feelings. Take the person seriously, and do not assume they are joking.
- **Help them connect** to resources, for example, by calling the National Suicide Prevention Lifeline (1-800-273-TALK (8255)) or by connecting the person to someone in the community who can help, e.g. emergency department, counselor, pastor.
- **Follow up** after the person is safe, follow up in the days ahead with a phone call, ask them how they are doing. See if there is anything else that you can do.

  You can learn more about these steps to help by going to www.bethe1to.com.

The way society handles suicide seems almost contradictory. When a celebrity dies this way, it is all over the news. When someone in the neighborhood or at work dies by suicide, it's the subject of unconfirmed rumor. Certainly, the survivors and family members are in pain and want privacy, but does suicide risk and the need for help for the populous at large carry a stigma that impedes life-saving treatment? In other words, should we, as a society, be talking about suicide more as a strategy to prevent these tragic losses?

Talking about suicide does not cause suicide to occur or put the thought in someone's head.

- In fact, **it can be an excellent prevention tool.**
  - Talking breaks the secrecy and shame that surrounds suicidal behavior and lets people know that help and hope are available.
- **By not talking about suicide, we increase the isolation and despair of individuals thinking about it and perpetuate the stigma associated with suicidal ideation and seeking help~~behavior~~.**

Everyone can play a role in suicide prevention. There are also recommendations for the media regarding how to report on suicide to raise awareness without increasing the risk of additional suicides among vulnerable populations. We know that risk can increase when the media provides details about the methods used, dramatic/graphic headlines, or glamorize a death (see reportingonsuicide.org).

We've talked a lot about risk and some barriers to suicide prevention like stigma, so let's turn the focus to saving lives. How can the CDC help public health professionals help their communities reduce the potential for suicide among their residents? What programs should public health professionals consider?

CDC put together specific strategies for ways that the federal government, state and communities, healthcare systems, employers and everyone can help prevent suicide:

The Federal government is

- Tracking the problem to describe trends, circumstances, and populations at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Working with local, state, tribal, national, and other partners to provide guidance and distribute suicide prevention tools (for example, see https://go.usa.gov/xQBGc).

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

Health care systems can

- Provide high quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

Employers can

Comment [ST(]: I don't think this long list works for Deb to respond to this question. The question is framed as what programs should public health professionals consider? I suggest making this more focused. It is also confusing to say CDC put together these specific strategies but then talk about the technical package later and list the strategies under "states and communities can" again. I think some editing is needed here and below to these points about prevention. This is critical because we want Deb Houry to feel confident about this.

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use disorder, legal, or financial counseling services as needed

Everyone can

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support like the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out how this can save a life by visiting: www.bethe1to.com.

And for members of the public who are listening, what can they do to protect their own families and their loved ones, or even their neighbors or colleagues?

No matter what problems people deal with, we want to help them find a reason to keep living. By calling 1-800-273-TALK (8255) people will be connected to a skilled, trained counselor at a crisis center in their area, anytime 24/7. There are many success stories and stories of hope where people in need have reached out and family or friends have intervened to get people help. They got the support they needed and were able to get through a crisis and go on to live productive and fulfilling lives.

Given the wide range of factors that contribute to suicide, this would seem to be a problem not easily solved?

- **While it's true that suicide does not have one cause, this means that there are multiple opportunities for prevention. A public health approach focuses more broadly on the opportunities to reduce risk ~~the research tells us that there are strategies that work to prevent it.~~**
    - ***~~The most effective strategies are comprehensive and use a public health approach~~ as opposed to focusing exclusively on mental health conditions. This can result in ~~, to have~~ a broader impact and reach more people at risk.*** There is also the issues of stigma around suicide and mental health care, which discourages people at risk for self-harm from seeking help. Suicide is preventable, but we need sufficient investment and a comprehensive public health approach.

Looking at this report, and the disturbing trend the numbers illustrate, what is the outlook? Is there any reason to be optimistic about the future?

Yes, the reason to be optimistic is that Suicide is preventable and we have strategies that ~~know what~~ works.

CDC released a technical package of policies, programs, and practices to prevent suicide to help communities focus on a core set of strategies that have the best available evidence and greatest prevention potential.

The technical package includes examples of programs that local implementers might tailor to fit the needs of their community. The technical package **includes 7 strategies designed to work together to achieve the greatest impact possible**.

i. Strengthen economic supports
ii. Strengthen access and delivery of suicide care
iii. Create protective environments
iv. Promote connectedness
v. Teach coping and problem-solving skills
vi. Identify and support people at risk
vii. Lessen harms and prevent future risk

For example, an evidenced based suicide prevention program called Sources of Strength was developed with rural and tribal communities in North Dakota to promote connectedness between youth and caring adults. The program works to understand and respond to underlying causes of suicidal behavior and promote protective factors against suicidal behavior before the causes result in adverse outcomes.

Other innovative prevention strategies, such as telebehavioral or telemental health (telephone, video and web-based technologies), are promising to increase access to health care and mental health care in rural communities. However, some rural communities may have limited access to the internet suggesting a need to increase broadband access and to identify other ways to deliver promising prevention supports where people live.

If you or someone you know is thinking about suicide or needs support, help is always available. Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or visit http://suicidepreventionlifeline.org

Comment [zaf9]: What's the reference for this? I'd like to make sure I'm more familiar with this success story.

Comment [VD]: Comes from this study referenced in the Suicide Technical package: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2920978/

Comment [ST(]: I think we should be strategic about the examples used. I suggest that you carefully consider the options from the technical package that will resonate the most with this audience. It would be helpful to use examples with results that you can describe.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 2 Aug 2018 03:09:36 +0000
To: Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: ADS Review: ASTHO Podcast
Attachments: ASTHO Suicide Podcast_v3 ds vd.docx

I don't have much more time to work on this but I think it should be close now.
Thanks!
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, August 1, 2018 5:15 PM
To: Daniel, Valerie M. (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: ADS Review: ASTHO Podcast

Ok, thank you both for clarifying and for continuing to work on this. It is already much better.

From: Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, August 1, 2018 12:32 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: ADS Review: ASTHO Podcast

Deb and Tom,
I put in some more messaging based on Deb's last version. Deb Stone, not Houry will be speaking on the ASTHO podcast. Sorry for the confusion. Too many Deb's ☺. As for the wording of the questions, they were provided by ASTHO who were shocked we had to clear Deb's content in order to participate (I guess NCEZID or some other center who had an SME participate on a past podcast didn't require this clearance, but I explained every Center was different) so they put together some questions for her to answer. I think it's fine to provide edits back.
Let me know what you all think of the attached.
Thanks,
Valerie

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, July 31, 2018 10:56 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: RE: ADS Review: ASTHO Podcast

Hi Tom,
Thanks for your review. I'm actually doing the podcast though unless something has changed that I don't know about (which would be fine)!
Taking your comments, I went ahead and added some stuff and moved some stuff around. It's not done yet but see what you think so far.
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Tuesday, July 31, 2018 6:13 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>

Cc: Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: ADS Review: ASTHO Podcast

Hi Erin and Valerie,

I added some edits in the version attached. Deb Houry has not spoken much publicly about suicide prevention and I think this is a good opportunity to help her "own" this content. We need to provide her with a strong document and there are a couple of places where the content could be improved. In particular, the results from the VS were not fully described. I added some bullets there to address this. I think the most important issue that still needs to be addressed is to tighten the prevention messages for her. I don't think we should simply use the lists from the fact sheet and TP. I think this needs to be more conversational. I'm also concerned because the text includes the 7 strategies from the TP twice (once under "states and communities can" and once when talking about the TP) and doesn't explain them in either place. I like the inclusion of some examples. I'm not sure the two selected are the best to use though. There are some that are more compelling because they have great results or will resonate with this audience. For example, the Air Force example is good because it demonstrates the value of a comprehensive approach and has effects that go beyond suicide prevention. I'm ccing Deb Stone because she likely has ideas for how to tighten the prevention points.

I hope this is helpful.

-Tom

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, July 27, 2018 9:20 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: FW: ADS Review: ASTHO Podcast

Meant to copy Val!

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, July 27, 2018 9:19 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: ADS Review: ASTHO Podcast

Tom – not sure if I should send this to you or Cory, let me know. Attached is the ASTHO podcast Question Q&A. Val used the pre-cleared Vital Signs Q&A on suicide to pull from when preparing responses to the questions. This has been reviewed by Deb, me, and Malia/Heather for policy. We are trying to get this cleared in time for Deb's recording of the podcast on August 6th at 2pm.

Thanks,
Erin

NCIPC OC Clearance:
DVP ADS Clearance:
DVP Policy Review: Malia Richmond-Crum, Heather Dennehy 7/26/18
DVP HCET Review: Erin Black, 7/24/18
DVP SME Review: Deb Stone 7/23/18

ASTHO Suicide Podcast

Questions for CDC guest

Your Vital Signs report tracks suicide rates over an 18-year period, 1999-2016, and finds that suicide is on the rise. What's happening?

- **Suicide is a public health problem.**
  - Nearly 45,000 lives were lost to suicide in 2016, which is approximately one suicide every 12 minutes.
  - Suicide and nonfatal self-harm injuries cost more than $69 billion annually in direct medical and work loss costs.
  - Suicide is one of just three leading causes of death that are on the rise.
  - We found that suicide rates increased in nearly every state across the nation.
  - 25 states had increases greater than 30%.

Do we know what is contributing to these increases?

While the Vital Statistics data are great for describing trends they don't tell us about the causal factors that are driving the increases.

We do know that suicide is not caused by any one factor, but instead, it is typically caused by a combination of individual, relationship, community, and societal factors.

Several factors could be contributing to the increases:

Economic conditions
The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability could have contributed to increases in suicide risk. Past research on the association between business cycles and U.S. suicide rates indicates that the overall suicide rate rises and falls in connection with the economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.

Opioid epidemic

When there is an increased availability and misuse of prescription opioids, we may see increases in suicide rates. Substance misuse itself is an established risk factor for suicide and, therefore, opioid misuse associated with the opioid overdose epidemic could be driving the suicide rate higher. When we look at who is dying from suicide and who is dying from unintentional overdoses involving opioids, we see that there is overlap in the demographics of the populations most highly affected by suicide and unintended opioid overdose deaths.

Social media

More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

Rural

While there have been increases and decreases in suicide rates over time, research shows that rates across cities and towns in the United States have been rising, with rural areas experiencing the most increases. The increased rates may be associated with suicide risk factors that are more common in less urban areas, such as limited access to mental healthcare as well as greater social isolation.

Let's explore the factors that can play into a person's decision to take his or her own life. What are they?

Many people think that suicide is an unexplainable act, when, in reality, many known factors increase risk.

These include:

- History of previous suicide attempts
- Family history of suicide
- History of child abuse and neglect or other adverse childhood experiences
- History of depression or other mental illness
- Alcohol or drug abuse
- Feelings of hopelessness or isolation
- Impulsive or aggressive tendencies
- Stressful life event or loss (e.g. relationship, job, money, criminal/legal problems)
- Easy access to lethal methods
- Exposure to the suicidal behavior of others
- Isolation, lack of social connectedness

To better understand the circumstances that contributed to suicide in our vital signs we looked at NVDRS data from 27 states. We found that more than half of people who died by suicide did not have a known mental health condition and that many factors contribute to suicide among those with and without a mental health condition, including:

- 42% relationship problems
- 29% crisis in the past or upcoming two weeks
- 28% problematic substance abuse
- 22% physical health problem
- 16% job/financial problem
- 9% legal problem
- 4% loss of housing

The presence of any one of these factors does not mean someone is thinking about suicide or will attempt suicide. Researchers agree that suicidal behavior results from an *interaction* of factors and is rarely due to a single cause.

How do I know if someone is at high risk of making a suicide attempt?

The warning signs for suicide are:

- Expressing hopelessness
- Increased anger or rage
- Extreme mood swings
- Sleeping too little or too much
- Making plans for suicide
- Talking and/or posting about wanting to die
- Feeling trapped or in unbearable pain
- Increased anxiety
- Securing lethal means
- Increased substance use
- Feeling like a burden
- Isolation

If you notice any of these signs:

- **Ask** the question, "Are you thinking about suicide?" Asking the question won't make someone suicidal, and instead, may relieve or reduce the feeling.
- If the person says yes, **keep** them safe. Find out if they have a suicide plan. Remove any lethal means in the environment, if possible, and do not leave the person alone.
- **Be there** and show concern. Don't act surprised or dismiss their feelings. Take the person seriously, and do not assume they are joking.
- **Help them connect** to resources, for example, by calling the National Suicide Prevention Lifeline (1-800-273-TALK (8255)) or by connecting the person to someone in the community who can help, e.g. emergency department, counselor, pastor.

- **Follow up** after the person is safe, follow up in the days ahead with a phone call, ask them how they are doing. See if there is anything else that you can do.

  You can learn more about these steps to help by going to www.bethe1to.com.

The way society handles suicide seems almost contradictory. When a celebrity dies this way, it is all over the news. When someone in the neighborhood or at work dies by suicide, it's the subject of unconfirmed rumor. Certainly, the survivors and family members are in pain and want privacy, but does suicide risk and the need for help for the populous at large carry a stigma that impedes life-saving treatment? In other words, should we, as a society, be talking about suicide more as a strategy to prevent these tragic losses?

Yes. We want to talk to people who may be at risk and we want to have the conversation more broadly. People should know that talking about suicide does not cause suicide to occur or put the thought in someone's head.

- In fact, it can be an excellent prevention tool.
  - Talking breaks the secrecy and shame that surrounds suicidal behavior and lets people know that help and hope are available.
- By not talking about suicide, we increase the isolation and despair of individuals thinking about it and perpetuate the stigma associated with suicidal ideation and seeking help.

More broadly speaking, conversation about suicide prevention is good. However, safe messaging about suicide is imperative. For example, we should be sure to provide messages of hope and resilience and assure people that help is available and that suicide is preventable.

Upstream prevention is important and can be used in messaging about- preventing risk from occurring the first place by communicating and being aware of the warning signs discussed previously for suicide (expressing hopelessness, sleeping too little or too much, increased anxiety, isolation) and if you notice someone acting these ways, taking action by talking to them, validating their feelings and connecting them to help. Messaging related to downstream activities are also important. How to speak to those at increased risk and how to prevent further re-attempts. Be there for the person at risk, follow up and check on them and help connect them to suicide prevention resources or counseling.

There are also recommendations for the media regarding how to report on suicide to raise awareness without increasing the risk of additional suicides among vulnerable populations. We know that risk can increase when the media provides details about the methods used, dramatic/graphic headlines, or glamorize a death (see reportingonsuicide.org).

We've talked a lot about risk and some barriers to suicide prevention like stigma, so let's turn the focus to saving lives. How can the CDC help public health professionals help their

communities reduce the potential for suicide among their residents? What programs should public health professionals consider?

~~To address the full range of contributing factors to suicide, comprehensive suicide prevention activities are needed.~~

~~Such strategies include both upstream prevention to prevent risk from occurring in the first place as well as more downstream activities responsive to the needs of people at increased risk and to prevent re-attempts.~~

- **CDC suggests a public health approach to suicide prevention that focuses more broadly on the opportunities to reduce risk *as opposed to focusing exclusively on mental health conditions. This can result in a broader impact and reach more people at risk.*** There is also the issues of stigma around suicide and mental health care, which discourages people at risk for self-harm from seeking help. Suicide is preventable, but we need sufficient investment and a comprehensive public health approach.
    - Such strategies include both upstream prevention to prevent risk from occurring in the first place, such as promoting connectedness, as well as more downstream activities responsive to the needs of people at increased risk and to prevent re-attempts through treatment interventions.

In 2017 CDC released, Preventing Suicide: A technical package of policy, programs, and practices. A technical package is a core set of strategies that have the best available evidence to prevent a public health problem, like suicide. They can help improve the health and well-being of communities.

- The technical package for suicide prevention includes **7 strategies designed to work together to achieve the greatest impact possible**. The strategies are presented in order from those with the greatest potential to produce broad public health impact on suicide followed by those with potential to impact subsets of the population (e.g., persons who have already made a suicide attempt).

- The seven strategies are:

i. Strengthen economic supports
ii. Strengthen access and delivery of suicide care
iii. Create protective environments
iv. Promote connectedness
v. Teach coping and problem-solving skills
vi. Identify and support people at risk
vii. Lessen harms and prevent future risk

Together these strategies represent a comprehensive approach to suicide prevention.

One example from the technical package of a successful program is **The United States Air Force Suicide Prevention Program**. This program, (which includes 11 policy and education initiatives designed to increase social support, social skills, and help-seeking) shifted the culture of the Air Force away from viewing suicide as an individual-oriented mental health concern to a larger, service-wide problem impacting the whole community. After the program was begun, the Air Force saw a 33% reduction in suicide as well as reductions in other related problems, such as severe family violence (54%) and homicide (51%).

And for members of the public who are listening, what can they do to protect their own families and their loved ones, or even their neighbors or colleagues?

No matter what problems people deal with, we want to help them find a reason to keep living. By calling 1-800-273-TALK (8255) people will be connected to a skilled, trained counselor at a crisis center in their area, anytime 24/7. There are many success stories and stories of hope where people in need have reached out and family or friends have intervened to get people help. They got the support they needed and were able to get through a crisis and go on to live productive and fulfilling lives.

Given the wide range of factors that contribute to suicide, this would seem to be a problem not easily solved?

- **While it's true that suicide does not have one cause, this means that there are multiple opportunities for prevention and everyone has a role.**

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Looking at this report, and the disturbing trend the numbers illustrate, what is the outlook? Is there any reason to be optimistic about the future?

Yes, the reason to be optimistic is that Suicide is preventable and we have strategies that work. Implementing a comprehensive approach to suicide prevention as laid out in our technical package and with everyone playing a role, we can strive to reach our national goal which is to reduce suicide 20% by 2025.

If you or someone you know is thinking about suicide or needs support, help is always available. Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or visit http://suicidepreventionlifeline.org

From: /o=cdc/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=f43dd520d1854120aa942ac284dc7713-discoverysearchmailb
Sent: 2 Aug 2018 02:32:21 +0000
To: Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Subject: RE: ADS Review: ASTHO Podcast

Hi Val,
I'm at an all day meeting tomorrow and so can't work on this again until tomorrow night probably.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, August 1, 2018 5:15 PM
To: Daniel, Valerie M. (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: ADS Review: ASTHO Podcast

Ok, thank you both for clarifying and for continuing to work on this. It is already much better.

From: Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, August 1, 2018 12:32 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
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Valerie

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Sent: Tuesday, July 31, 2018 10:56 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
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Attachments: ASTHO Suicide Podcast_v3 ds vd.docx

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ASTHO Suicide Podcast

Questions for CDC guest

Your Vital Signs report tracks suicide rates over an 18-year period, 1999-2016, and finds that suicide is on the rise. What's happening?

- **Suicide is a public health problem.**
  - Nearly 45,000 lives were lost to suicide in 2016, which is approximately one suicide every 12 minutes.
  - Suicide and nonfatal self-harm injuries cost more than $69 billion annually in direct medical and work loss costs.
  - Suicide is one of just three leading causes of death that are on the rise.
  - We found that suicide rates increased in nearly every state across the nation.
  - 25 states had increases greater than 30%.

Do we know what is contributing to these increases?

While the Vital Statistics data are great for describing trends they don't tell us about the causal factors that are driving the increases.

We do know that suicide is not caused by any one factor, but instead, it is typically caused by a combination of individual, relationship, community, and societal factors.

Several factors could be contributing to the increases:

Economic conditions
The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability could have contributed to increases in suicide risk. Past research on the association between business cycles and U.S. suicide rates indicates that the overall suicide rate rises and falls in connection with the economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.

Opioid epidemic

Comment [ST(]: I don't understand why this was written like this. The period of the MMWR was 1999-2016 and this is 18 years not 10.

Comment [VD]: Tom, fine to provide edits to the questions. ASTHO drafted them.

Comment [ST(]: I'm requesting edits here to provide the VS results.

Comment [SD(]: I like these. I think I'd say something like, What's happening unfortunately is that suicide is a growing public health problem. Our Vital Signs report indicated that In 2016, 45000 people lost their lives to suicide and over the period 1999-2016 suicide increased in nearly every state. In fact rates increased by more than 30% in half of all US states.

We know that suicide is just the tip of the iceberg. Many more people attempt suicide or think about suicide than actually die. In fact, suicide and self-harm injuries cost the nation more than $69 billion in 2016.

Then I might wait for the question again about increases and go into the next section. Can we ask for the question to be inserted here?

When there is an increased availability and misuse of prescription opioids, we may see increases in suicide rates. Substance misuse itself is an established risk factor for suicide and, therefore, opioid misuse associated with the opioid overdose epidemic could be driving the suicide rate higher. When we look at who is dying from suicide and who is dying from unintentional overdoses involving opioids, we see that there is overlap in the demographics of the populations most highly affected by suicide and unintended opioid overdose deaths.

Social media

More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

Rural

While there have been increases and decreases in suicide rates over time, research shows that rates across cities and towns in the United States have been rising, with rural areas experiencing the most increases. The increased rates may be associated with suicide risk factors that are more common in less urban areas, such as limited access to mental healthcare as well as greater social isolation.

Let's explore the factors that can play into a person's decision to take his or her own life. What are they?

Many people think that suicide is an unexplainable act, when, in reality, many known factors increase risk.

These include:

- History of previous suicide attempts
- Family history of suicide
- History of child abuse and neglect or other adverse childhood experiences
- History of depression or other mental illness
- Alcohol or drug abuse
- Feelings of hopelessness or isolation
- Impulsive or aggressive tendencies
- Stressful life event or loss (e.g. relationship, job, money, criminal/legal problems)
- Easy access to lethal methods
- Exposure to the suicidal behavior of others
- Isolation, lack of social connectedness

To better understand the circumstances that contributed to suicide in our vital signs we looked at NVDRS data from 27 states. We found that more than half of people who died by suicide did not have a known mental health condition and that many factors contribute to suicide among those with and without a mental health condition, including ;

- 42% relationship problems
- 29% crisis in the past or upcoming two weeks
- 28% problematic substance abuse
- 22% physical health problem
- 16% job/financial problem
- 9% legal problem
- 4% loss of housing

Comment [SD(]: Moved this here

The presence of any one of these factors does not mean someone is thinking about suicide or will attempt suicide. Researchers agree that suicidal behavior results from an *interaction* of factors and is rarely due to a single cause.

How do I know if someone is at high risk of making a suicide attempt?

The warning signs for suicide are:

- Expressing hopelessness
- Increased anger or rage
- Extreme mood swings
- Sleeping too little or too much
- Making plans for suicide
- Talking and/or posting about wanting to die
- Feeling trapped or in unbearable pain
- Increased anxiety
- Securing lethal means
- Increased substance use
- Feeling like a burden
- Isolation

If you notice any of these signs:

- **Ask** the question, "Are you thinking about suicide?" Asking the question won't make someone suicidal, and instead, may relieve or reduce the feeling.
- If the person says yes, **keep** them safe. Find out if they have a suicide plan. Remove any lethal means in the environment, if possible, and do not leave the person alone.
- **Be there** and show concern. Don't act surprised or dismiss their feelings. Take the person seriously, and do not assume they are joking.
- **Help them connect** to resources, for example, by calling the National Suicide Prevention Lifeline (1-800-273-TALK (8255)) or by connecting the person to someone in the community who can help, e.g. emergency department, counselor, pastor.

- **Follow up** after the person is safe, follow up in the days ahead with a phone call, ask them how they are doing. See if there is anything else that you can do.

  You can learn more about these steps to help by going to www.bethe1to.com.

The way society handles suicide seems almost contradictory. When a celebrity dies this way, it is all over the news. When someone in the neighborhood or at work dies by suicide, it's the subject of unconfirmed rumor. Certainly, the survivors and family members are in pain and want privacy, but does suicide risk and the need for help for the populous at large carry a stigma that impedes life-saving treatment? In other words, should we, as a society, be talking about suicide more as a strategy to prevent these tragic losses?

Yes. First off people should know that talking about suicide does not cause suicide to occur or put the thought in someone's head.

- In fact, it can be an excellent prevention tool.
  - Talking breaks the secrecy and shame that surrounds suicidal behavior and lets people know that help and hope are available.
- By not talking about suicide, we increase the isolation and despair of individuals thinking about it and perpetuate the stigma associated with suicidal ideation and seeking help.

More broadly speaking, conversation about suicide prevention is good. However, safe messaging about suicide is imperative. For example, we should be sure to provide messages of hope and assure people that help is available and that suicide is preventable.

Upstream prevention is important and can be used in messaging about- preventing risk from occurring the first place by communicating and being aware of the warning signs discussed previously for suicide (expressing hopelessness, sleeping too little or too much, increased anxiety, isolation) and if you notice someone acting these ways, taking action by talking to them, validating their feelings and connecting them to help. Messaging related to downstream activities are also important. How to speak to those at increased risk and how to prevent further re-attempts. Be there for the person at risk, follow up and check on them and help connect them to suicide prevention resources or counseling.

There are also recommendations for the media regarding how to report on suicide to raise awareness without increasing the risk of additional suicides among vulnerable populations. We know that risk can increase when the media provides details about the methods used, dramatic/graphic headlines, or glamorize a death (see reportingonsuicide.org).

We've talked a lot about risk and some barriers to suicide prevention like stigma, so let's turn the focus to saving lives. How can the CDC help public health professionals help their communities reduce the potential for suicide among their residents? What programs should public health professionals consider?

Comment [SD(]: I think this question is asking about whether in general as a population we should be discussing suicide prevention more and raising awareness etc..I can make the point directly below but I think this question is also about messaging about suicide and making sure we are doing so safely in the media but also in our awareness activities etc.. We need to provide messages of hope, talk about helping resources, and how to prevent suicide.

Comment [VD]: Deb, I built in some more language about this. Feel free to edit or tweak as needed.

- To address the full range of contributing factors to suicide, comprehensive suicide prevention activities are needed.
    - Such strategies include both upstream prevention to prevent risk from occurring in the first place as well as more downstream activities responsive to the needs of people at increased risk and to prevent re-attempts.

- **CDC suggests a public health approach to suicide prevention that focuses more broadly on the opportunities to reduce risk *as opposed to focusing exclusively on mental health conditions. This can result in a broader impact and reach more people at risk.*** There is also the issues of stigma around suicide and mental health care, which discourages people at risk for self-harm from seeking help. Suicide is preventable, but we need sufficient investment and a comprehensive public health approach.

  CDC released a technical package of policies, programs, and practices to prevent suicide to help communities focus on a core set of strategies that have the best available evidence and greatest prevention potential.

  The technical package includes examples of programs that local implementers might tailor to fit the needs of their community. The technical package **includes 7 strategies designed to work together to achieve the greatest impact possible.**

  i. Strengthen economic supports
  ii. Strengthen access and delivery of suicide care
  iii. Create protective environments
  iv. Promote connectedness
  v. Teach coping and problem-solving skills
  vi. Identify and support people at risk
  vii. Lessen harms and prevent future risk

  Insert Air Force example

Comment [VD]: Might be good to provide some examples here of upstream and downstream or we may be fine since you discuss this previously now.

Comment [SD(]: Would work on this a bit more. Would talk about upstream and downstream approaches and comprehensive prevention then transition to technical package.

Comment [SD(]: I could work on this a bit.

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Do we know what is contributing to these increases?

While the Vital Statistics data are great for describing trends they don't tell us about the causal factors that are driving the increases.

We do know that suicide is not caused by any one factor, but instead, it is typically caused by a combination of individual, relationship, community, and societal factors.

~~To better understand the circumstances that contributed to suicide we looked at NVDRS data from 17 states. We found that more than half of people who died by suicide did not have a known mental health condition. Mhighlighted in our past Vital Signs many other factors that contribute to suicide among those with and without a mental health condition, including :~~

~~42% relationship problems~~
~~29% crisis in the past or upcoming two weeks~~
~~28% problematic substance abuse~~
~~22% physical health problem~~
~~16% job/financial problem~~

Comment [ST(]: I don't understand why this was written like this. The period of the MMWR was 1999-2016 and this is 18 years not 10.

Comment [ST(]: I'm requesting edits here to provide the VS results.

Comment [SD(]: I like these. I think I'd say something like, What's happening unfortunately is that suicide is a growing public health problem. Our Vital Signs report indicated that In 2016, 45000 people lost their lives to suicide and over the period 1999-2016 suicide increased in nearly every state. In fact rates increased by more than 30% in half of all US states.

We know that suicide is just the tip of the iceberg. Many more people attempt suicide or think about suicide than actually die. In fact, suicide and self-harm injuries cost the nation more than $69 billion in 2016.

Then I might wait for the question again about increases and go into the next section. Can we ask for the question to be inserted here?

~~3% legal problem~~
~~4% loss of housing~~

Comment [SD(]: This might be better placed under the next question about risk factors. And instead, here, I'd go into the next set of points on the next page related to increases.

Several factors ~~Several such factors~~ could be contributing to the increases:

Economic conditions
The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability could have contributed to increases in suicide risk. Past research on the association between business cycles and U.S. suicide rates indicates that the overall suicide rate rises and falls in connection with the economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.

Opioid epidemic
When there is an increased availability and misuse of prescription opioids, we may see increases in suicide rates. Substance misuse itself is an established risk factor for suicide and, therefore, opioid misuse associated with the opioid overdose epidemic could be driving the suicide rate higher. When we look at who is dying from suicide and who is dying from unintentional overdoses involving opioids, we see that there is overlap in the demographics of the populations most highly affected by suicide and unintended opioid overdose deaths.

Social media
More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

Rural
While there have been increases and decreases in suicide rates over time, research shows that rates across cities and towns in the United States have been rising, with rural areas experiencing the most increases. The increased rates may be associated with suicide risk factors that are more common in less urban areas, such as limited access to mental healthcare as well as greater social isolation.

Let's explore the factors that can play into a person's decision to take his or her own life. What are they?

Many people think that suicide is an unexplainable act, when, in reality, many known factors increase risk ~~across the individual, relationship, community, and societal~~ levels.

These include:

- History of previous suicide attempts
- Family history of suicide
- History of child abuse and neglect or other adverse childhood experiences
- History of depression or other mental illness
- Alcohol or drug abuse
- Feelings of hopelessness or isolation
- Impulsive or aggressive tendencies
- Stressful life event or loss (e.g. relationship, job, money, criminal/legal problems)
- Easy access to lethal methods
- Exposure to the suicidal behavior of others
- Isolation, lack of social connectedness

To better understand the circumstances that contributed to suicide in our vital signs we looked at NVDRS data from 27 states. We found that more than half of people who died by suicide did not have a known mental health condition and that many factors contribute to suicide among those with and without a mental health condition, including :

- 42% relationship problems
- 29% crisis in the past or upcoming two weeks
- 28% problematic substance abuse
- 22% physical health problem
- 16% job/financial problem
- 9% legal problem
- 4% loss of housing

The presence of any one of these factors does not mean someone is thinking about suicide or will attempt suicide. Researchers agree that suicidal behavior results from an *interaction* of factors and is rarely due to a single cause.

How do I know if someone is at high risk of making a suicide attempt?

The warning signs for suicide are:

- Expressing hopelessness
- Increased anger or rage
- Extreme mood swings
- Sleeping too little or too much
- Making plans for suicide
- Talking and/or posting about wanting to die~~suicide~~
- Feeling trapped or in unbearable pain

Comment [ST(]: I don't think you need to complicate the list with this.

Comment [SD(]: Moved this here

- Increased anxiety
- Securing lethal means
- Increased substance use
- Feeling like a burden
- Isolation

If you notice any of these signs:

- **Ask** the question, "Are you thinking about suicide?" Asking the question won't make someone suicidal, and instead, may relieve or reduce the feeling.
- If the person says yes, **keep** them safe. Find out if they have a suicide plan. Remove any lethal means in the environment, if possible, and do not leave the person alone.
- **Be there** and show concern. Don't act surprised or dismiss their feelings. Take the person seriously, and do not assume they are joking.
- **Help them connect** to resources, for example, by calling the National Suicide Prevention Lifeline (1-800-273-TALK (8255)) or by connecting the person to someone in the community who can help, e.g. emergency department, counselor, pastor.
- **Follow up** after the person is safe, follow up in the days ahead with a phone call, ask them how they are doing. See if there is anything else that you can do.

You can learn more about these steps to help by going to www.bethe1to.com.

The way society handles suicide seems almost contradictory. When a celebrity dies this way, it is all over the news. When someone in the neighborhood or at work dies by suicide, it's the subject of unconfirmed rumor. Certainly, the survivors and family members are in pain and want privacy, but does suicide risk and the need for help for the populous at large carry a stigma that impedes life-saving treatment? In other words, should we, as a society, be talking about suicide more as a strategy to prevent these tragic losses?

Yes. First off people should know that t~~T~~alking about suicide does not cause suicide to occur or put the thought in someone's head.

- In fact, it can be an excellent prevention tool.
  - Talking breaks the secrecy and shame that surrounds suicidal behavior and lets people know that help and hope are available.
- By not talking about suicide, we increase the isolation and despair of individuals thinking about it and perpetuate the stigma associated with suicidal ideation and seeking help~~behavior~~.

More broadly speaking, conversation about suicide prevention is good. However, safe messaging about suicide is imperative. For example, we should be sure to provide messages of hope and assure people that help is available and that suicide is preventable.

~~Everyone can play a role in suicide prevention.~~ There are also ~~also~~ recommendations for the media regarding how to report on suicide to raise awareness without increasing the risk of additional suicides among vulnerable populations. We know that risk can increase when the

Comment [SD(]: I think this question is asking about whether in general as a population we should be discussing suicide prevention more and raising awareness etc..I can make the point directly below but I think this question is also about messaging about suicide and making sure we are doing so safely in the media but also in our awareness activities etc.. We need to provide messages of hope, talk about helping resources, and how to prevent suicide.

media provides details about the methods used, dramatic/graphic headlines, or glamorize a death (see reportingonsuicide.org).

We've talked a lot about risk and some barriers to suicide prevention like stigma, so let's turn the focus to saving lives. How can the CDC help public health professionals help their communities reduce the potential for suicide among their residents? What programs should public health professionals consider?

- **CDC suggests a public health approach to suicide prevention that focuses more broadly on the opportunities to reduce risk *as opposed to focusing exclusively on mental health conditions. This can result in a broader impact and reach more people at risk.*** There is also the issues of stigma around suicide and mental health care, which discourages people at risk for self-harm from seeking help. Suicide is preventable, but we need sufficient investment and a comprehensive public health approach.

  CDC released a technical package of policies, programs, and practices to prevent suicide to help communities focus on a core set of strategies that have the best available evidence and greatest prevention potential.

  The technical package includes examples of programs that local implementers might tailor to fit the needs of their community. The technical package **includes 7 strategies designed to work together to achieve the greatest impact possible**.

  i. Strengthen economic supports
  ii. Strengthen access and delivery of suicide care
  iii. Create protective environments
  iv. Promote connectedness
  v. Teach coping and problem-solving skills
  vi. Identify and support people at risk
  vii. Lessen harms and prevent future risk

  Insert Air Force example

And for members of the public who are listening, what can they do to protect their own families and their loved ones, or even their neighbors or colleagues?

No matter what problems people deal with, we want to help them find a reason to keep living. By calling 1-800-273-TALK (8255) people will be connected to a skilled, trained counselor at a crisis center in their area, anytime 24/7. There are many success stories and stories of hope where people in need have reached out and family or friends have intervened to get people help. They got the support they needed and were able to get through a crisis and go on to live productive and fulfilling lives.

Comment [SD(]: Would work on this a bit more. Would talk about upstream and downstream approaches and comprehensive prevention then transition to technical package.

Comment [SD(]: I could work on this a bit.

Given the wide range of factors that contribute to suicide, this would seem to be a problem not easily solved?

- **While it's true that suicide does not have one cause, this means that there are multiple opportunities for prevention** and everyone has a role. ~~. A public health approach focuses more broadly on the opportunities to reduce risk the research tells us that there are strategies that work to prevent it.~~
- ~~***The most effective strategies are comprehensive and use a public health approach as opposed to focusing exclusively on mental health conditions. This can result in , to have a broader impact and reach more people at risk.*** There is also the issues of stigma around suicide and mental health care, which discourages people at risk for self-harm from seeking help. Suicide is preventable, but we need sufficient investment and a comprehensive public health approach.CDC put together specific strategies for ways that the federal government, state and communities, healthcare systems, employers and everyone can help prevent suicide:~~
-

For its part The Federal government is

- Tracking the problem to describe trends, circumstances, and populations at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Working with local, state, tribal, national, and other partners to provide guidance and distribute suicide prevention tools (for example, see https://go.usa.gov/xQBGc).

States and communities can implement the seven strategies from the technical package.

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

Comment [SD(]: Moved this here.

Health care systems can

- Provide high quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

Employers can

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use disorder, legal, or financial counseling services as needed

Everyone can

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support like the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out how this can save a life by visiting: www.bethe1to.com.

Looking at this report, and the disturbing trend the numbers illustrate, what is the outlook? Is there any reason to be optimistic about the future?

> ***Yes, the reason to be optimistic is that Suicide is preventable and we have strategies that ~~know what~~ works.*** Implementing a comprehensive approach to suicide prevention as laid out in our technical package and with everyone playing a role, we can strive to reach our national goal which is to reduce suicide 20% by 2025.

If you or someone you know is thinking about suicide or needs support, help is always available. Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or visit http://suicidepreventionlifeline.org

From: /o=cdc/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=f43dd520d1854120aa942ac284dc7713-discoverysearchmailb
Sent: 1 Aug 2018 01:51:45 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC)
Cc: Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Subject: RE: ADS Review: ASTHO Podcast

Hi Tom,
Thanks for your review. I'm actually doing the podcast though unless something has changed that I don't know about (which would be fine)!
I made some additional comments in the document. I didn't have time to add as much as I wanted because I have to go to bed. Mostly I just moved some things around.
I agree that the air force program is good to highlight.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Tuesday, July 31, 2018 6:13 PM
To: Black, Erin (CDC/ONDIEH/NCIPC)
Cc: Daniel, Valerie M. (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: ADS Review: ASTHO Podcast

Hi Erin and Valerie,
I added some edits in the version attached. Deb Houry has not spoken much publicly about suicide prevention and I think this is a good opportunity to help her "own" this content. We need to provide her with a strong document and there are a couple of places where the content could be improved. In particular, the results from the VS were not fully described. I added some bullets there to address this. I think the most important issue that still needs to be addressed is to tighten the prevention messages for her. I don't think we should simply use the lists from the fact sheet and TP. I think this needs to be more conversational. I'm also concerned because the text includes the 7 strategies from the TP twice (once under "states and communities can" and once when talking about the TP) and doesn't explain them in either place. I like the inclusion of some examples. I'm not sure the two selected are the best to use though. There are some that are more compelling because they have great results or will resonate with this audience. For example, the Air Force example is good because it demonstrates the value of a comprehensive approach and has effects that go beyond suicide prevention. I'm ccing Deb Stone because she likely has ideas for how to tighten the prevention points.
I hope this is helpful.
-Tom

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, July 27, 2018 9:20 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: FW: ADS Review: ASTHO Podcast

Meant to copy Val!

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, July 27, 2018 9:19 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
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Tom – not sure if I should send this to you or Cory, let me know. Attached is the ASTHO podcast Question Q&A. Val used the pre-cleared Vital Signs Q&A on suicide to pull from when preparing

responses to the questions. This has been reviewed by Deb, me, and Malia/Heather for policy. We are trying to get this cleared in time for Deb's recording of the podcast on August 6th at 2pm.
Thanks,
Erin

From: /o=cdc/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=f43dd520d1854120aa942ac284dc7713-discoverysearchmailb
Sent: 31 Jul 2018 23:37:20 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC)
Cc: Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Subject: RE: ADS Review: ASTHO Podcast

Hi Tom,
I'm actually doing the podcast, not Deb Houry! I can work on fixing this up but

---

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Thanks,
Erin

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 4 Apr 2018 13:11:02 +0000
To: Caine, Eric
Subject: RE: AJPH Opinion Editorial

Hi Eric,
Sorry I missed your call yesterday. I had a half day meeting and then somehow missed that I had a call when I finally did get back to my office.
Ok, I'm glad you are able to edit it down. My heartache has lessened. Thanks for sending when you're done.
Deb

From: Caine, Eric
Sent: Tuesday, April 3, 2018 8:09 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Re: AJPH Opinion Editorial

Deb—Heartache? What's happened?
I have comments back and have begun to edit, with an eye to 1200 words. I will send to Alex and to you.
I left a phone message at work today…but I guess you are not in the office.
Eric

Eric D. Caine, M.D.
University of Rochester Medical Ctr.
300 Crittenden Blvd.
Rochester, NY, USA 14642-8409
[p] +1 585.746.3574

From: Deborah Stone <zaf9@cdc.gov>
Date: Tuesday, April 3, 2018 at 7:37 PM
To: "Caine, Eric" <Eric_Caine@URMC.Rochester.edu>
Subject: FW: AJPH Opinion Editorial

Hi Eric,
Thanks for sending along the editorial. I have some comments but what's giving me heartache at the moment is that I just realized this is not in the 1200 word limit (highlighted below). Did you think it was 1800 words?
Would you still be able to revise?? Also, I'd like to have Alex review. Please let me know what you think.
Deb

From: Caine, Eric <Eric_Caine@URMC.Rochester.edu>
Sent: Tuesday, February 27, 2018 9:33 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; jarrod.hindman@state.co.us; Reed, Jerry <jreed@edc.org>
Subject: Re: AJPH Opinion Editorial

Glad to, too!

Eric D. Caine, M.D.
University of Rochester Medical Ctr.
300 Crittenden Blvd.
Rochester, NY, USA 14642-8409
[p] +1 585.746.3574

From: Deborah Stone <zaf9@cdc.gov>
Date: Monday, February 26, 2018 at 5:34 PM
To: "Caine, Eric" <Eric_Caine@URMC.Rochester.edu>, Jarrod Hindman

<jarrod.hindman@state.co.us>, Jerry Reed <jreed@edc.org>

Subject: AJPH Opinion Editorial

Hi Guys,

As you may have heard from me? others? CDC is releasing a *Vital Signs* on Suicide on June 5th. This is a really high profile/high impact publication. It includes a website, MMWR, Fact Sheet, Social Media messages, press release, telebriefing by Acting CDC Director and a Town Hall Meeting (We already have on record that the Surgeon General *may* participate in the telebriefing). Vital Signs sometimes also include an accompanying commentary in a peer reviewed journal. What does this have to do with you? I know you are probably tired of being singled out for all of your great work and perspectives…(sorry!) but would the three of you or some combination of you do us the honor of writing an opinion editorial (1200 words, 7 references,) for us in AJPH about comprehensive suicide prevention and CO efforts [we can refine later but for purposes here, this is the topic]? I'm happy to set up a call to discuss but in the meantime, please see attached Vital Signs description with preliminary results (Please do not distribute or otherwise use or I'll probably be fired). Also see recent Vital Signs (on opioids) and the companion commentary. Also, editorial is due to AJPH **April 5th**!! So it's coming right up. Oy.

Look forward to hearing of your interest and thoughts.

Deb

Deb Stone, ScD, MSW, MPH
Behavioral Scientist
Suicide, Youth Violence, and Elder Maltreatment Team
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Research & Evaluation Branch
4770 Buford Highway, MS F-64
Atlanta, GA 30341
770.488.3942
dstone3@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 28 Feb 2018 00:08:34 +0000
To: Hindman - CDPHE, Jarrod;Reed, Jerry
Cc: Caine, Eric;Betz, Marian
Subject: RE: AJPH Opinion Editorial

Hi Jarrod,
Emmy was on the invite. If you want me to just call in to your line, I'm happy to do that and can revise the invite. Is this the number, 888.330.3581; access code (b)(6)
Deb
From: Hindman - CDPHE, Jarrod [mailto:jarrod.hindman@state.co.us]
Sent: Tuesday, February 27, 2018 7:05 PM
To: Reed, Jerry
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Caine, Eric ; Betz, Marian
Subject: Re: AJPH Opinion Editorial
Sorry. Just saw Deb's appointment. Disregard my suggestion on the call-in. Deb - can you add Emmy to the appointment you sent? Thanks.
jarrod
On Tue, Feb 27, 2018 at 5:02 PM, Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us> wrote:

> Adding Emmy to the conversation in case she is available after our already scheduled call. We will be using the ICRC-S call for our 1pm EDT call, so I'm wondering if we can just stay on the line and Deb can join us at 2pm EDT? Eric - does that work?
> jarrod
> On Tue, Feb 27, 2018 at 3:13 PM, Reed, Jerry <jreed@edc.org> wrote:
>
> > Do we have a call in #?
> > Jerry
> > **Jerry Reed, PhD, MSW**
> > Senior Vice President for Practice Leadership
> > Suicide, Violence & Injury Prevention Portfolio Lead
> > National Action Alliance for Suicide Prevention Executive Committee Member
> > jreed@edc.org | 202-572-3771 (O) | 202-294-8132 (M) | 202-223-4059 (F)
> > **Education Development Center, Inc.**
> >
> > 
> >
> >
> > **From:** Stone, Deborah (CDC/ONDIEH/NCIPC) [mailto:zaf9@cdc.gov]
> > **Sent:** Tuesday, February 27, 2018 4:27 PM
> > **To:** Reed, Jerry <jreed@edc.org>; Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us>
> >
> > **Cc:** Caine, Eric <Eric_Caine@urmc.rochester.edu>
> > **Subject:** RE: AJPH Opinion Editorial
> > I have another call that ends at 2 so may be a min or two late if that's ok. But agree with hard stop at 3.
> > Deb

From: Reed, Jerry [mailto:jreed@edc.org]
Sent: Tuesday, February 27, 2018 3:13 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us>
Cc: Caine, Eric <Eric_Caine@urmc.rochester.edu>
Subject: RE: AJPH Opinion Editorial

I could do Friday at 2PM. Hard stop at 3. And Had start at 2.

Best,

Jerry

Jerry Reed, PhD, MSW
Senior Vice President for Practice Leadership
Suicide, Violence & Injury Prevention Portfolio Lead
National Action Alliance for Suicide Prevention Executive Committee Member
jreed@edc.org | 202-572-3771 (O) | 202-294-8132 (M) | 202-223-4059 (F)
Education Development Center, Inc.



From: Stone, Deborah (CDC/ONDIEH/NCIPC) [mailto:zaf9@cdc.gov]
Sent: Tuesday, February 27, 2018 2:53 PM
To: Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us>
Cc: Caine, Eric <Eric_Caine@urmc.rochester.edu>; Reed, Jerry <jreed@edc.org>
Subject: RE: AJPH Opinion Editorial

Great, thanks Jarrod! I can do Friday at 2 if everyone else is free.

Deb

From: Hindman - CDPHE, Jarrod [mailto:jarrod.hindman@state.co.us]
Sent: Tuesday, February 27, 2018 2:35 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Caine, Eric <Eric_Caine@urmc.rochester.edu>; Reed, Jerry <jreed@edc.org>
Subject: Re: AJPH Opinion Editorial

I'm in, sorry for my late reply.

Of the times you noted for a call, I can do:

- Wed 3pm
- Thurs at 1pm
- Friday at 2pm

Deb - Jerry, Eric, Emmy and I already have a call on the books for Friday at 1, so perhaps 2pm might work well? Would be great to include Emmy as well if possible.

Jarrod

On Tue, Feb 27, 2018 at 9:41 AM, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov> wrote:

> Fabulous! Assuming Jarrod is on board as well, until I hear differently!
> Do any of these times work (all EST) to meet this week? Also, wanted to discuss some CDC Foundation stuff as well. I had a follow-up call with them today after our last CNC meeting.
>
> • Wed 3 pm

- Wed 4 pm
- Thurs 10 am
- Thurs 1 pm
- Friday anytime except 1-2 pm

Deb

From: Caine, Eric [mailto:Eric_Caine@URMC.Rochester.edu]
Sent: Tuesday, February 27, 2018 9:33 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; jarrod.hindman@state.co.us; Reed, Jerry <jreed@edc.org>
Subject: Re: AJPH Opinion Editorial

☐Glad to, too!

Eric D. Caine, M.D.
University of Rochester Medical Ctr.
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Subject: AJPH Opinion Editorial

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Look forward to hearing of your interest and thoughts.

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Jarrod Hindman, MS

Deputy Chief

Violence and Injury Prevention-Mental Health Promotion Branch

P 303.692.2539 | F 303.691.7901

4300 Cherry Creek Drive South, Denver CO 80246

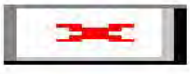
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From: Hindman - CDPHE, Jarrod
Sent: 27 Feb 2018 17:04:37 -0700
To: Reed, Jerry
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC);Caine, Eric;Betz, Marian
Subject: Re: AJPH Opinion Editorial

Sorry. Just saw Deb's appointment. Disregard my suggestion on the call-in. Deb - can you add Emmy to the appointment you sent? Thanks.

jarrod

On Tue, Feb 27, 2018 at 5:02 PM, Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us> wrote:

> Adding Emmy to the conversation in case she is available after our already scheduled call. We will be using the ICRC-S call for our 1pm EDT call, so I'm wondering if we can just stay on the line and Deb can join us at 2pm EDT? Eric - does that work?
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> > National Action Alliance for Suicide Prevention Executive Committee Member
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> Eric D. Caine, M.D.

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Date: Monday, February 26, 2018 at 5:34 PM
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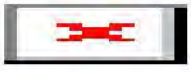
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From: Betz, Marian
Sent: 28 Feb 2018 00:04:06 +0000
To: Reed, Jerry;Hindman - CDPHE, Jarrod
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC);Caine, Eric
Subject: Re: AJPH Opinion Editorial

Works for me, but with hard stop 245 for me (3pm meeting elsewhere)

Get Outlook for Android

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Cc: Stone, Deborah (CDC/ONDIEH/NCIPC), Caine, Eric, Betz, Marian

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> **Sent:** Tuesday, February 27, 2018 9:33 AM
> **To:** Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; jarrod.hindman@state.co.us; Reed, Jerry <jreed@edc.org>
> **Subject:** Re: AJPH Opinion Editorial
>
> Glad to, too!
> Eric D. Caine, M.D.
> University of Rochester Medical Ctr.
> 300 Crittenden Blvd.
> Rochester, NY, USA 14642-8409
> [p] +1 585.746.3574
>
> **From:** Deborah Stone <zaf9@cdc.gov>
> **Date:** Monday, February 26, 2018 at 5:34 PM
> **To:** "Caine, Eric" <Eric_Caine@URMC.Rochester.edu>, Jarrod Hindman <jarrod.hindman@state.co.us>, Jerry Reed <jreed@edc.org>
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Jarrod Hindman, MS

Deputy Chief

Violence and Injury Prevention-Mental Health Promotion Branch

P 303.692.2539 | F 303.691.7901

4300 Cherry Creek Drive South, Denver CO 80246

jarrod.hindman@state.co.us |

From: Reed, Jerry
Sent: 27 Feb 2018 20:12:46 +0000
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Hindman - CDPHE, Jarrod
Cc: Caine, Eric
Subject: RE: AJPH Opinion Editorial

I could do Friday at 2PM. Hard stop at 3. And Had start at 2.
Best,
Jerry

Jerry Reed, PhD, MSW
Senior Vice President for Practice Leadership
Suicide, Violence & Injury Prevention Portfolio Lead
National Action Alliance for Suicide Prevention Executive Committee Member
jreed@edc.org | 202-572-3771 (O) | 202-294-8132 (M) | 202-223-4059 (F)
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jarrod.hindman@state.co.us |

From: Hindman - CDPHE, Jarrod
Sent: 6 Mar 2018 12:18:39 -0700
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Re: AJPH Opinion Editorial

Sounds good. Thanks Deb.

On Tue, Mar 6, 2018 at 12:01 PM, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov> wrote:

> No worries. We can just discuss tomorrow. I'm swamped as well!
>
> Deb
>
> **From:** Hindman - CDPHE, Jarrod [mailto:jarrod.hindman@state.co.us]
> **Sent:** Tuesday, March 6, 2018 1:59 PM
> **To:** Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
> **Cc:** Reed, Jerry <jreed@edc.org>; Betz, Marian <MARIAN.BETZ@ucdenver.edu>; Eric_Caine@URMC.Rochester.edu
>
> **Subject:** Re: AJPH Opinion Editorial
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> > **Sent:** Monday, March 5, 2018 12:42 PM
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> > **Cc:** Betz, Marian <MARIAN.BETZ@ucdenver.edu>; Eric_Caine@URMC.Rochester.edu; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
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> Best,
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> **Jerry Reed, PhD, MSW**
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> Senior Vice President for Practice Leadership
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> Suicide, Violence & Injury Prevention Portfolio Lead
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> National Action Alliance for Suicide Prevention Executive Committee Member
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>
> **Education Development Center, Inc.**
>
> 
>
>
> **From:** Betz, Marian [mailto:MARIAN.BETZ@UCDENVER.EDU]
> **Sent:** Friday, March 02, 2018 5:02 PM
> **To:** Eric_Caine@URMC.Rochester.edu; jarrod.hindman@state.co.us; Reed, Jerry <jreed@edc.org>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
>
> **Subject:** RE: AJPH Opinion Editorial
>
> Hi all,
>
> Just switching to my work email from gmail for this email chain – please use this address for responses.

Great talking to you all, and Eric let me know how/when I can help out with the paper.

Emmy

Marian (Emmy) Betz, MD, MPH

Associate Professor| Department of Emergency Medicine | University of Colorado School of Medicine
Core Faculty | Program for Injury Prevention, Education and Research (PIPER) | Colorado School of Public Health

Mail Stop B-215 | Leprino Office Building, 7th Floor, 12401 E. 17th Avenue |Aurora, CO 80045

Phone: 720.848.6770 | Marian.Betz@ucdenver.edu | Cell: 303.550.5669 | Twitter: @EmmyBetz


Department of Emergency Medicine
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From: Emmy Betz <mebetz@gmail.com>
Sent: Friday, March 02, 2018 3:00 PM
To: Betz, Marian <marian.betz@ucdenver.edu>
Subject: Fwd: AJPH Opinion Editorial

---------- Forwarded message ----------
From: **Stone, Deborah (CDC/ONDIEH/NCIPC)** <zaf9@cdc.gov>
Date: Fri, Mar 2, 2018 at 1:47 PM
Subject: RE: AJPH Opinion Editorial
To: "Caine, Eric (Eric_Caine@URMC.Rochester.edu)" <Eric_Caine@urmc.rochester.edu>, "jarrod.hindman@state.co.us" <jarrod.hindman@state.co.us>, "Reed, Jerry" <jreed@edc.org>, Emmy Betz <mebetz@gmail.com>

Thank you for a productive (and entertaining call). But seriously, I do so appreciate your willingness to write this editorial to accompany the Vital Signs.

This is going to be a great product (collectively).

Attaching drafts of everything so far so you can get the full effect of what we're going for.

Based on the titles and watermarks and PDF file type I think you'll figure out not to share. ;)

The draft of the MMWR hasn't been reviewed yet so take it with a grain of salt, especially the discussion which needs lots o work.

Also, please do review these two links to see an example of how the vital signs and the editorial link together. Vital Signs (on opioids) and the companion commentary.

Let me know if you have any questions about anything.

Dates to keep in mind:

Week of March 12th—Outline to Deb

March 23- Copy of article to share with CDC for soft edits

April 5th—Article due to AJPH

Thankful for this partnership!! (now but in general) ;)

Happy Friday.

Deb

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, February 26, 2018 5:31 PM
To: Caine, Eric (Eric_Caine@URMC.Rochester.edu) <Eric_Caine@URMC.Rochester.edu>; jarrod.hindman@state.co.us; Reed, Jerry <jreed@edc.org>
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To: Reed, Jerry;Caine, Eric (Eric_Caine@URMC.Rochester.edu);jarrod.hindman@state.co.us
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Thanks, Jerry!! ☺
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Best,
Jerry

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Hi all,

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Great talking to you all, and Eric let me know how/when I can help out with the paper.

Emmy

Marian (Emmy) Betz, MD, MPH
Associate Professor| Department of Emergency Medicine | University of Colorado School of Medicine
Core Faculty | Program for Injury Prevention, Education and Research (PIPER) | Colorado School of Public Health
Mail Stop B-215 | Leprino Office Building, 7th Floor, 12401 E. 17th Avenue |Aurora, CO 80045
Phone: 720.848.6770 | Marian.Betz@ucdenver.edu | Cell: 303.550.5669 | Twitter: @EmmyBetz
Department of Emergency Medicine
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS
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From: Emmy Betz <mebetz@gmail.com>
Sent: Friday, March 02, 2018 3:00 PM
To: Betz, Marian <marian.betz@ucdenver.edu>
Subject: Fwd: AJPH Opinion Editorial

---------- Forwarded message ----------
From: **Stone, Deborah (CDC/ONDIEH/NCIPC)** <zaf9@cdc.gov>
Date: Fri, Mar 2, 2018 at 1:47 PM
Subject: RE: AJPH Opinion Editorial
To: "Caine, Eric (Eric_Caine@URMC.Rochester.edu)" <Eric_Caine@urmc.rochester.edu>, "jarrod.hindman@state.co.us" <jarrod.hindman@state.co.us>, "Reed, Jerry" <jreed@edc.org>, Emmy Betz <mebetz@gmail.com>

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From: Hindman - CDPHE, Jarrod
Sent: 6 Mar 2018 11:59:18 -0700
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Reed, Jerry;Betz, Marian;Eric_Caine@URMC.Rochester.edu
Subject: Re: AJPH Opinion Editorial

Hey Deb. I'm pretty much booked the rest of this afternoon, other than the next hour. If we can't touch base, is it feasible to update the group on the call tomorrow morning? Or, do we need to save the conversation / update for later?

Jarrod

On Mon, Mar 5, 2018 at 11:11 AM, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov> wrote:

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To: Hindman - CDPHE, Jarrod;Reed, Jerry
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Also, please do review these two links to see an example of how the vital signs and the editorial link together. Vital Signs (on opioids) and the companion commentary.
Let me know if you have any questions about anything.

Dates to keep in mind:

Week of March 12th—Outline to Deb
March 23- Copy of article to share with CDC for soft edits
April 5th—Article due to AJPH
Thankful for this partnership!! (now but in general) ;)
Happy Friday.
Deb

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, February 26, 2018 5:31 PM
To: Caine, Eric (Eric_Caine@URMC.Rochester.edu) <Eric_Caine@URMC.Rochester.edu>; jarrod.hindman@state.co.us; Reed, Jerry <jreed@edc.org>
Subject: AJPH Opinion Editorial

Hi Guys,

As you may have heard from me? others? CDC is releasing a *Vital Signs* on Suicide on June 5th. This is a really high profile/high impact publication. It includes a website, MMWR, Fact Sheet, Social Media messages, press release, telebriefing by Acting CDC Director and a Town Hall Meeting (We already have on record that the Surgeon General *may* participate in the telebriefing). Vital Signs sometimes also include an accompanying commentary in a peer reviewed journal. What does this have to do with you? I know you are probably tired of being singled out for all of your great work and perspectives…(sorry!) but would the three of you or some combination of you do us the honor of writing an opinion editorial (1200 words, 7 references,) for us in AJPH about comprehensive suicide prevention and CO efforts [we can refine later but for purposes here, this is the topic]? I'm happy to set up a call to discuss but in the meantime, please see attached Vital Signs description with preliminary results (Please do not distribute or otherwise use or I'll probably be fired). Also see recent Vital Signs (on opioids) and the companion commentary. Also, editorial is due to AJPH **April 5th**!! So it's coming right up. Oy.
Look forward to hearing of your interest and thoughts.
Deb

Deb Stone, ScD, MSW, MPH
Behavioral Scientist
Suicide, Youth Violence, and Elder Maltreatment Team
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Division of Violence Prevention
Research & Evaluation Branch
4770 Buford Highway, MS F-64
Atlanta, GA 30341
770.488.3942
dstone3@cdc.gov

From: Betz, Marian
Sent: 2 Mar 2018 22:02:06 +0000
To: Eric_Caine@URMC.Rochester.edu;jarrod.hindman@state.co.us;Reed, Jerry;Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: AJPH Opinion Editorial

Hi all,
Just switching to my work email from gmail for this email chain – please use this address for responses.

Great talking to you all, and Eric let me know how/when I can help out with the paper.
Emmy

Marian (Emmy) Betz, MD, MPH
Associate Professor| Department of Emergency Medicine | University of Colorado School of Medicine
Core Faculty | Program for Injury Prevention, Education and Research (PIPER) | Colorado School of Public Health
Mail Stop B-215 | Leprino Office Building, 7th Floor, 12401 E. 17th Avenue |Aurora, CO 80045
Phone: 720.848.6770 | Marian.Betz@ucdenver.edu | Cell: 303.550.5669 | Twitter: @EmmyBetz
Department of Emergency Medicine
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**
Confidentiality Notice: This email message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message.

From: Emmy Betz
Sent: Friday, March 02, 2018 3:00 PM
To: Betz, Marian
Subject: Fwd: AJPH Opinion Editorial
---------- Forwarded message ----------
From: **Stone, Deborah (CDC/ONDIEH/NCIPC)** <zaf9@cdc.gov>
Date: Fri, Mar 2, 2018 at 1:47 PM
Subject: RE: AJPH Opinion Editorial
To: "Caine, Eric (Eric_Caine@URMC.Rochester.edu)" <Eric_Caine@urmc.rochester.edu>, "jarrod.hindman@state.co.us" <jarrod.hindman@state.co.us>, "Reed, Jerry" <jreed@edc.org>, Emmy Betz <mebetz@gmail.com>

Thank you for a productive (and entertaining call). But seriously, I do so appreciate your willingness to write this editorial to accompany the Vital Signs.
This is going to be a great product (collectively).
Attaching drafts of everything so far so you can get the full effect of what we're going for.
Based on the titles and watermarks and PDF file type I think you'll figure out not to share. ;)
The draft of the MMWR hasn't been reviewed yet so take it with a grain of salt, especially the discussion which needs lots o work.
Also, please do review these two links to see an example of how the vital signs and the editorial link together. Vital Signs (on opioids) and the companion commentary.
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Deb

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Sent: Monday, February 26, 2018 5:31 PM
To: Caine, Eric (Eric_Caine@URMC.Rochester.edu) <Eric_Caine@URMC.Rochester.edu>; jarrod.hindman@state.co.us; Reed, Jerry <jreed@edc.org>
Subject: AJPH Opinion Editorial

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Look forward to hearing of your interest and thoughts.

Deb

Deb Stone, ScD, MSW, MPH
Behavioral Scientist
Suicide, Youth Violence, and Elder Maltreatment Team
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Research & Evaluation Branch
4770 Buford Highway, MS F-64
Atlanta, GA 30341
770.488.3942
dstone3@cdc.gov

From: Hindman - CDPHE, Jarrod
Sent: 27 Feb 2018 17:25:47 -0700
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Reed, Jerry;Caine, Eric;Betz, Marian
Subject: Re: AJPH Opinion Editorial

That's it. Thanks Deb!

Jh

On Tue, Feb 27, 2018 at 5:08 PM, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov> wrote:

> Hi Jarrod,
>
> Emmy was on the invite. If you want me to just call in to your line, I'm happy to do that and can revise the invite. Is this the number, 888.330.3581; access code - (b)(6)
>
> Deb
>
> **From:** Hindman - CDPHE, Jarrod [mailto:jarrod.hindman@state.co.us]
> **Sent:** Tuesday, February 27, 2018 7:05 PM
> **To:** Reed, Jerry <jreed@edc.org>
> **Cc:** Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Caine, Eric <Eric_Caine@urmc.rochester.edu>; Betz, Marian <MARIAN.BETZ@ucdenver.edu>
>
> **Subject:** Re: AJPH Opinion Editorial
>
> Sorry. Just saw Deb's appointment. Disregard my suggestion on the call-in. Deb - can you add Emmy to the appointment you sent? Thanks.
>
> jarrod
>
> On Tue, Feb 27, 2018 at 5:02 PM, Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us> wrote:
>
>> Adding Emmy to the conversation in case she is available after our already scheduled call. We will be using the ICRC-S call for our 1pm EDT call, so I'm wondering if we can just stay on the line and Deb can join us at 2pm EDT? Eric - does that work?
>>
>> jarrod
>>
>> On Tue, Feb 27, 2018 at 3:13 PM, Reed, Jerry <jreed@edc.org> wrote:
>>
>>> Do we have a call in #?

Jerry

Jerry Reed, PhD, MSW

Senior Vice President for Practice Leadership

Suicide, Violence & Injury Prevention Portfolio Lead

National Action Alliance for Suicide Prevention Executive Committee Member

jreed@edc.org | 202-572-3771 (O) | 202-294-8132 (M) | 202-223-4059 (F)

Education Development Center, Inc.



From: Stone, Deborah (CDC/ONDIEH/NCIPC) [mailto:zaf9@cdc.gov]
Sent: Tuesday, February 27, 2018 4:27 PM
To: Reed, Jerry <jreed@edc.org>; Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us>

Cc: Caine, Eric <Eric_Caine@urmc.rochester.edu>
Subject: RE: AJPH Opinion Editorial

I have another call that ends at 2 so may be a min or two late if that's ok. But agree with hard stop at 3.

Deb

From: Reed, Jerry [mailto:jreed@edc.org]
Sent: Tuesday, February 27, 2018 3:13 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us>
Cc: Caine, Eric <Eric_Caine@urmc.rochester.edu>
Subject: RE: AJPH Opinion Editorial

I could do Friday at 2PM. Hard stop at 3. And Had start at 2.

Best,

Jerry

Jerry Reed, PhD, MSW

Senior Vice President for Practice Leadership

Suicide, Violence & Injury Prevention Portfolio Lead

National Action Alliance for Suicide Prevention Executive Committee Member

jreed@edc.org | 202-572-3771 (O) | 202-294-8132 (M) | 202-223-4059 (F)

Education Development Center, Inc.

From: Stone, Deborah (CDC/ONDIEH/NCIPC) [mailto:zaf9@cdc.gov]
Sent: Tuesday, February 27, 2018 2:53 PM
To: Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us>
Cc: Caine, Eric <Eric_Caine@urmc.rochester.edu>; Reed, Jerry <jreed@edc.org>
Subject: RE: AJPH Opinion Editorial

Great, thanks Jarrod! I can do Friday at 2 if everyone else is free.

Deb

From: Hindman - CDPHE, Jarrod [mailto:jarrod.hindman@state.co.us]
Sent: Tuesday, February 27, 2018 2:35 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Caine, Eric <Eric_Caine@urmc.rochester.edu>; Reed, Jerry <jreed@edc.org>
Subject: Re: AJPH Opinion Editorial

I'm in, sorry for my late reply.

Of the times you noted for a call, I can do:

- Wed 3pm

- Thurs at 1pm

- Friday at 2pm

Deb - Jerry, Eric, Emmy and I already have a call on the books for Friday at 1, so perhaps 2pm might work well? Would be great to include Emmy as well if possible.

Jarrod

On Tue, Feb 27, 2018 at 9:41 AM, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov> wrote:

> Fabulous! Assuming Jarrod is on board as well, until I hear differently!
>
> Do any of these times work (all EST) to meet this week? Also, wanted to discuss some CDC Foundation stuff as well. I had a follow-up call with them today after our last CNC meeting.

- Wed 3 pm
- Wed 4 pm
- Thurs 10 am
- Thurs 1 pm
- Friday anytime except 1-2 pm

Deb

From: Caine, Eric [mailto:Eric_Caine@URMC.Rochester.edu]
Sent: Tuesday, February 27, 2018 9:33 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; jarrod.hindman@state.co.us; Reed, Jerry <jreed@edc.org>
Subject: Re: AJPH Opinion Editorial

Glad to, too!

Eric D. Caine, M.D.

University of Rochester Medical Ctr.

300 Crittenden Blvd.

Rochester, NY, USA 14642-8409

[p] +1 585.746.3574

From: Deborah Stone <zaf9@cdc.gov>
Date: Monday, February 26, 2018 at 5:34 PM
To: "Caine, Eric" <Eric_Caine@URMC.Rochester.edu>, Jarrod Hindman <jarrod.hindman@state.co.us>, Jerry Reed <jreed@edc.org>
Subject: AJPH Opinion Editorial

Hi Guys,

As you may have heard from me? others? CDC is releasing a *Vital Signs* on Suicide on June 5th. This is a really high profile/high impact publication. It includes a website, MMWR, Fact Sheet, Social Media messages, press release, telebriefing by Acting CDC Director and a Town Hall Meeting (We already have on record that the Surgeon General *may* participate in the telebriefing). Vital Signs sometimes also include an accompanying commentary in a peer reviewed journal. What does this have to do with you? I know you are probably tired of being singled out for all of your great work and perspectives…(sorry!) but would the three of you or some combination of you do us the honor of writing an opinion editorial (1200 words, 7 references,) for us in AJPH about comprehensive suicide prevention and CO efforts [we

can refine later but for purposes here, this is the topic]? I'm happy to set up a call to discuss but in the meantime, please see attached Vital Signs description with preliminary results (Please do not distribute or otherwise use or I'll probably be fired). Also see recent Vital Signs (on opioids) and the companion commentary. Also, editorial is due to AJPH **April 5th**!! So it's coming right up. Oy.

Look forward to hearing of your interest and thoughts.

Deb

Deb Stone, ScD, MSW, MPH

Behavioral Scientist

Suicide, Youth Violence, and Elder Maltreatment Team

Centers for Disease Control and Prevention

National Center for Injury Prevention and Control

Division of Violence Prevention

Research & Evaluation Branch

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Atlanta, GA 30341

770.488.3942

dstone3@cdc.gov

--

Jarrod Hindman, MS

Deputy Chief

Violence and Injury Prevention-Mental Health Promotion Branch

P 303.692.2539 | F 303.691.7901

4300 Cherry Creek Drive South, Denver CO 80246

jarrod.hindman@state.co.us |

--

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4300 Cherry Creek Drive South, Denver CO 80246
jarrod.hindman@state.co.us |

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 19 Apr 2018 20:41:24 +0000
To: American Journal of Public Health Editor
Subject: RE: CDC Commentary for a June Vital Signs on Suicide
Attachments: AJPH-S-18-01098.pdf
Importance: High

Dear Dr. Morabia,
Thank you for your support of our CDC Vital Signs. My colleague, Dr. Eric Caine from the University of Rochester, NY submitted the editorial on April 5th as you requested but to date he has not heard anything back about the status of his submission.
I'm attaching the submission here for your convenience. Any guidance you can provide to keep this on track for a June 7th release would be so appreciated.
Sincerely,
Deb Stone

From: American Journal of Public Health Editor
Sent: Monday, February 19, 2018 2:56 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Re: CDC Commentary for a June Vital Signs on Suicide

Dear Deb Stone,
I am happy to offer an opinion editorial in AJPH to accompany the Vital Signs.
If I get it by April 5 it could appear online a few days after June 5 2018.
Sincerely,
Alfredo Morabia, MD, PhD
Editor-in-Chief, AJPH
Twitter | AJPH

From: Morabia, Alfredo <am52@cumc.columbia.edu>
Sent: Thursday, February 15, 2018 11:41 PM
To: American Journal of Public Health Editor
Subject: Fw: CDC Commentary for a June Vital Signs on Suicide

---

From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Sent: Thursday, February 15, 2018 5:57 PM
To: am52@columbia.edu
Cc: Preventive.Medicine@qc.cuny.edu
Subject: CDC Commentary for a June Vital Signs on Suicide

Dear Dr. Morabia,
My name is Deb Stone. I'm a behavioral scientist at CDC in the Division of Violence Prevention. I am leading the publication of a CDC Vital Signs focused on suicide to be released **June 5, 2018.** *Vital Signs*, as you may know, began in 2010 and is a high profile monthly CDC publication widely distributed to highlight important public health threats and what can be done to prevent them. The release always includes a web page, an MMWR article, a translation piece (i.e. fact sheet), science clips, and a telebriefing by the CDC Director with the media. It also often includes a companion commentary piece in a top tier journal, linked on our CDC Vital Signs web site and referenced in the other materials.

I am writing to inquire whether AJPH may be interested in collaborating with us to publish such a commentary. The commentary intends to integrate our study findings and the work of one state that is pioneering the first-ever comprehensive community-based public health approach to suicide prevention.

I believe that both the *Vital Signs* article and the journal companion piece will attract a great deal of attention. This is the debut feature on suicide in a Vital Signs and the results are highly compelling and relevant to a wide public health audience (see description below) including states, prevention practitioners, and providers. In addition, the U.S. Surgeon General has also expressed interest in conducting a town hall meeting as part of the wider release.

BRIEF DESCRIPTION: Suicide rates have increased nearly 30% between 1999 and 2016. To address this serious and growing problem, the proposed *Vital Signs* will use data from the *National Vital Statistics System* (NVSS, 1999-2016) and *National Violent Death Reporting System* (NVDRS, 2015). The trends in suicide rates in the U.S. overall and *by state* and sex, will be reported for the first time. Changes in state rankings over time will also be included. To help the reader fully understand and appreciate the multiple factors influencing suicide risk, the report will also compare the many social and environmental circumstances preceding suicide among people with and without known mental health problems. Preventive solutions will be offered that focus on a comprehensive population-based approach using the best available evidence as described in the CDC's Suicide Prevention Technical Package.

We have selected *AJPH* as our journal of choice for this commentary as we believe its reputation for high quality science and public health prevention most closely aligns with our message and our target audience. We hope that you will partner with us as we forge this exciting territory.

For your convenience, here is an example of a relatively recent Vital Signs (on opioids) and the companion commentary.

I look forward to your reply and the opportunity to provide additional information.

Sincerely,

Deb Stone

Deb Stone, ScD, MSW, MPH
Behavioral Scientist
Suicide, Youth Violence, and Elder Maltreatment Team
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
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American Journal of Public Health

Now is the time for…a Public Health, Comprehensive, Integrated Approach to Preventing Suicide

--Manuscript Draft--

Manuscript Number:	
Article Type:	Editorial
Keywords:	suicide prevention; public health; comprehensive
Corresponding Author:	Eric D Caine, M.D. University of Rochester Medical Center Rochester, NY UNITED STATES
First Author:	Eric D Caine, M.D.
Order of Authors:	Eric D Caine, M.D.
Full Title:	Now is the time for…a Public Health, Comprehensive, Integrated Approach to Preventing Suicide
Manuscript Classifications:	12: Community Health; 34: Health Professionals; 45: Injury/Emergency Care/Violence; 51: Mental Health; 55: Prevention; 56: Public Health Practice
Author Comments:	This editorial is submitted in the context of a forthcoming MMWR report (due for publication 5 June 2028) from the Division of Violence Prevention, National Center of Injury Prevention and Control, CDC. The authors of that report asked if we would be willing to prepare an editorial for AJPH timed to coincide with the release of the MMWR piece. We also were given an advanced copy of what is being prepared. We stipulated that whatever we would write would be our own opinions. While we welcomed the advanced copy, we also that indicated anything we prepared would NOT be subject to approval by CDC personnel or administration. Once that was agreed to, we prepared this manuscript for your review. I did let CDC personnel look at the near-final draft yesterday to let them know what we would be submitting. Aside from some grammatical 'stuff' that I and my colleagues missed, and a suggestion to add a date for my comment a comparing the number of overdose and suicide deaths (which I had already), there were no changes to ideas, comments, points of view, etc. Thank you for considering what my co-authors and I consider to be an important and timely submission. Yours truly, Eric Caine
Additional Information:	
Question	**Response**
Please list the Abstract word count for this document. This count is forwarded to the Editors and Reviewers as part of the evaluation process.	0
Please list the main text word count for this document. This count excludes the abstract, figures and tables, and references and is forwarded to the Editors and Reviewers as part of the evaluation process.	1260
Please list the number of references in this document. This count is forwarded to the Editors and Reviewers as part of the evaluation process.	6

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Please list the number of Tables and Figures and Supplemental Tables and Figures in this document. This count is forwarded to the Editors and Reviewers as part of the evaluation process. Please report counts as follows: Figures: #; Tables: #; Supplemental Tables: #; Supplemental Figures: # (where # represents the actual count of submitted Tables and Figures).	0
Affiliations Statement	Eric D. Caine, MD Injury Control Research Center for Suicide Prevention Department of Psychiatry University of Rochester Medical Center Rochester, NY Jarrod Hindman, MS Colorado Department of Public Health and Environment Violence and Injury Prevention--Mental Health Promotion Branch Denver, Colorado Jerry Reed, PhD, MSW Injury Control Research Center for Suicide Prevention Education Development Center Washington, DC Marian E. Betz, MD, MPH Department of Emergency Medicine University of Colorado School of Medicine Denver, Colorado
Acknowledgments and Disclosure	Drs. Caine and Reed are supported, in part, by grant R49 CE002093 (E.D. Caine, PI) from the Centers for Disease Control. All opinions expressed are those of the authors and not of CDC.
Human Participant Protection statement	N/A

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Cover Letter

SCHOOL OF MEDICINE & DENTISTRY

Department of Psychiatry

Eric D. Caine, M.D.
Professor of Psychiatry
Director, Injury Control Research Center
for Suicide Prevention (ICRC-S)

5 April 2018

Alfredo Morabia, MD, PhD
Editor
American Journal of Public Health

Dear Dr. Morabia:

This editorial is submitted on behalf of my colleagues and me in the context of a forthcoming MMWR report (due for publication 5 June 2028) from the Division of Violence Prevention, National Center of Injury Prevention and Control, CDC. The authors of that report asked if we would be willing to prepare an editorial for AJPH timed to coincide with the release of their MMWR piece. We also were given an advanced draft of what is being prepared.

In our initial discussion, we stipulated that whatever we would write would be our own opinions. While we welcomed the advanced copy, we also that indicated anything we prepared would *not* be subject to approval by CDC personnel or administration. Once that was agreed to, we prepared this manuscript for your review.

I did let CDC personnel look at the near-final draft yesterday to let them know what we would be submitting to you. Aside from some grammatical 'stuff' that I and my colleagues missed, a couple of word clarifications, and a suggestion to add a date for my comment comparing the number of overdose and suicide deaths (which I had in hand already), there were no changes to ideas, comments, points of view, etc.

We very much appreciate your time and consideration!

Yours truly,

Eric

Eric D. Caine, M.D.

300 Crittenden Boulevard – Box Psych – Rochester, NY 14642
+1-585-746-3574 ~ eric_caine@urmc.rochester.edu

Manuscript
Click here to download Manuscript AJPH Suicide Editorial_related to 06.05.18 MMWR.docx

Now is the time for...a Public Health, Comprehensive, Integrated Approach to Preventing Suicide

The rapidly rising tide of suicides and risk-related drug overdose deaths (collectively, "self-injury mortality;" SIM) has contributed substantially to decreasing U.S. life expectancy.[1] This national crisis reflects fraying social fabric as well as individual vulnerabilities: Indeed, these deaths serve simultaneously as measures of community health and indicators of individual well-being.[1] They potentially signal greater trouble ahead for our nation and its states and communities.

This week's MMWR, from CDC's Division of Violence Prevention, underscores the extraordinary burden of lives lost to suicides, deaths whose effects ramify widely throughout families and communities. The U.S. crude suicide rate in 2000 was 10.40 per 100,000 lives, rising by 2016 to 13.92, an overall increase of 33.8%,[2] with an uneven impact across states. Moreover, this likely is an under-estimate, due to mounting fatal opioid overdoses, many of which are codified as "accidents" by medical examiners and coroners in the absence of definitive evidence of intent to die.[3] Antecedent psychological, family, and social factors that contribute to suicides, as identified in the MMWR report, also are common to deaths from drug overdoses.[1] The cumulative national burden of SIM now equals or exceeds that of diabetes—albeit, rendering many more years of life lost because the bulk of these deaths occur before age 55.[4]

We bring to this discussion perspectives represented by the Colorado National Collaborative (CNC). This collective of local, state and national partners is working to design, implement and rigorously evaluate a coherent set of initiatives to save lives by preventing suicides, and SIM more generally, reaching persons of all ages living in urban and rural communities across Colorado.

Efforts to roll back this rising tide largely have depended on interceding when individuals are in-crisis or have survived a suicide attempt. While these are essential emergency interventions, a fundamental reduction in rates will require aggressively addressing 'upstream' factors to steer individuals away from lethal life trajectories as well as downstream access to needed clinical services. In an analogous fashion, mortality reductions from cardiac-vascular disorders followed promotion of positive health habits, smoking cessation, and increasing exercise; screening for antecedent indicators of future clinical disorders; and fostering cultural transformation among health care providers and health systems to identify treatable "risk factors" rather than awaiting later adverse events. Lasting reductions in suicides and related adverse outcomes will depend on highly integrated, comprehensive public health programs—upstream and downstream programs as well as crisis services—implemented with the committed involvement of local communities.

It is best that we define what we mean by *public* health, *comprehensive*, and *integrated*. Each term connotes implicates that may not be considered when facing the complex social, policy, and health challenges that are inherent to preventing suicides.

Public health must embrace the challenge of reducing stigma. Suicide, and frequently linked mental health and substance use disorders as well as fraught social, economic, and family issues, have been an intensely private, closely-held matters shrouded by shame and silence. How many people would accept such issues as *public* (health) concerns?

Comparable silence once shrouded issues such as breast cancer and HIV/AIDS. However, champions of social change and fighters of stigma made it acceptable to seek support, advocate for lasting cultural transformation, and make demands for policy change and research funding.[5] Opioid deaths now are grabbing national attention and new funding. Suicides exceeded all overdose fatalities until 2016,[2] but they never generated a sense of public urgency. Some clinicians, researchers, and policy makers considered suicide as a relatively rare outcome specific to high-risk persons rather than a result, in part, of societal forces. Broadly applied prevention efforts will not be effective until there is a collective imperative to save lives otherwise lost, not simply focusing on uniquely vulnerable individuals, many of whom were viewed previously as weak or defective and responsible for their own fate.

Comprehensive requires an appreciation of where in communities it is possible to engage potentially vulnerable populations long before individual members become suicidal. It requires an understanding of those social factors and policies that promote well-being, while seeking to mitigate those that degrade families and communities, however inadvertent or intentional they may be. Systemic, strategic, and encompassing, it requires the development of programs based on data about overall burden as well as death rates. It means binding together community organizations and committed individuals that already are involved while recruiting new ones, as well as reducing structural and fiscal barriers between health systems and communities.

Comprehensive also requires changing values in the general population—to bring full meaning to public health—by building and reinforcing a *shared culture of safety and caring*. Firearms are the method used in half of U.S. suicides.[2] A recent study showed that only one-third of gun-owning households stored firearms unloaded and locked; there was no difference between families with a youth who had risks for self-harm versus other homes.[6] Broadly supported discussions to promote safe homes—whether involving guns, poisons or medications, or slippery rugs that are hazards for elders—should be the purview of a society that cares about its citizens. Working with firearm retailers and owners, pharmacies, and poison control experts will be essential for creating an atmosphere of culturally-attuned respect and common purpose, and safer homes.

Similarly, *comprehensive* must include more effective use of social media to promote mental health and caring communities, especially in the current Wild West of the Internet. The latter too often serves as a platform for sharing of suicide-tinged themes, bullying, and social discourse promoting shame and humiliation, especially among teens and young adults. There remains insufficient understanding of how to instigate the type of exchanges and virtual communities that diminish vulnerabilities, promote a helping-society, and foster public health.

Integrated is especially challenging in our country, which has no central health authority, unlike countries that have successfully implemented their national strategies. There has been substantial progress uniting national level activities through the National Action Alliance for Suicide Prevention (a public-private partnership), together with CDC, NIMH, SAMHSA, VA, and DoD. However, it has been challenging to forge state and local coalitions that have the collective moral and statutory authority, as well as the necessary resources, to conduct effective, persisting efforts. The U.S. is too large and too diverse to launch and sustain local actions that 'reach the ground' based on Federal activities alone.

At the same time, national level efforts have provided many of the tools essential to building effective, lasting local partnerships, and already have offered inspiration, guidance, and support. These include the 2012 *National Strategy for Suicide Prevention* (NSSP; https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html) and the consistent record of funding through the Garrett Lee Smith Memorial Act since 2005, which serves youth between the ages of 10-24 years. Recently, grants from NSSP, SAMHSA (Zero Suicide), and CDC have focused on adults. This past year the National Action Alliance released its report, *Transforming Communities* (http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/TransformingCommunitiesPaper.pdf), helping to facilitate the development of effective local-state partnerships. CDC's Division of Violence Prevention of CDC's published, *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf). The latter offers a review of evidence-based tools, complementing materials from the SAMHSA-funded Suicide Prevention Resource Center (https://www.sprc.org).

These tools provide valuable assistance for building evidence-based programs that depend on measuring outcomes and defining what works in an accountable fashion. Ultimately, the development of an effective, sustained, comprehensive set of integrated public health programs will depend on the commitment—the political and social will—of states, cities, and diverse communities (both geographically defined and reflecting common interests) to build structures that reach far and wide. Federal leadership and scientific knowledge are necessary but not sufficient. Local determination can make the difference.

1. Case, A., Deaton, A, Mortality and morbidity in the 21st century, in Brookings Panel on Economic Activity, March 23-24, 2017. 2017, Brookings Institute.
2. WISQARS, Fatal Injury Reports, National and Regional, 1999 - 2016, National Center for Injury Prevention and Control. Accessed March 26, 2018, Centers for Disease Control and Prevention.
3. Rockett, I.R.H., et al., Discerning suicide in drug intoxication deaths: Paucity and primacy of suicide notes and psychiatric history. PLOS ONE, 2018. 13(1): p. e0190200.
4. Rockett, I.H., et al., Self-injury mortality in the united states in the early 21st century: A comparison with proximally ranked diseases. JAMA Psychiatry, 2016. 73(10): p. 1072-1081.
5. Lytle, M.C., V.B. Silenzio, and E.D. Caine, Are there still too few suicides to generate public outrage? JAMA Psychiatry, 2016. 73(10): p. 1003-1004.
6. Scott, J., D. Azrael, and M. Miller, Firearm Storage in Homes With Children With Self-Harm Risk Factors. Pediatrics, 2018. 141(3).

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 29 Mar 2018 23:08:43 +0000
To: American Journal of Public Health Editor
Subject: RE: CDC Commentary for a June Vital Signs on Suicide

Dear Dr. Morabia,
Per the email correspondence below, Dr. Eric Caine will be submitting an opinion editorial to you by April 5th. Is there is a special way to submit this so that it can be flagged for publication a few days after June 5th or does it get submitted in the typical way via the editorial manager?
Also, I wanted to ask if there's any way the op-ed can come out *on* June 5th in line with our vital signs release? If not, as you indicate a few days after June 5th will be fine.
Thank you so much.
Sincerely,
Deb Stone

From: American Journal of Public Health Editor
Sent: Monday, February 19, 2018 2:56 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Re: CDC Commentary for a June Vital Signs on Suicide

Dear Deb Stone,
I am happy to offer an opinion editorial in AJPH to accompany the Vital Signs.
If I get it by April 5 it could appear online a few days after June 5 2018.
Sincerely,
Alfredo Morabia, MD, PhD
Editor-in-Chief, AJPH
Twitter | AJPH

From: Morabia, Alfredo <am52@cumc.columbia.edu>
Sent: Thursday, February 15, 2018 11:41 PM
To: American Journal of Public Health Editor
Subject: Fw: CDC Commentary for a June Vital Signs on Suicide

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From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Sent: Thursday, February 15, 2018 5:57 PM
To: am52@columbia.edu
Cc: Preventive.Medicine@qc.cuny.edu
Subject: CDC Commentary for a June Vital Signs on Suicide

Dear Dr. Morabia,
My name is Deb Stone. I'm a behavioral scientist at CDC in the Division of Violence Prevention. I am leading the publication of a CDC Vital Signs focused on suicide to be released **June 5, 2018.** *Vital Signs*, as you may know, began in 2010 and is a high profile monthly CDC publication widely distributed to highlight important public health threats and what can be done to prevent them. The release always includes a web page, an MMWR article, a translation piece (i.e. fact sheet), science clips, and a telebriefing by the CDC Director with the media. It also often includes a companion commentary piece in a top tier journal, linked on our CDC Vital Signs web site and referenced in the other materials.

I am writing to inquire whether AJPH may be interested in collaborating with us to publish such a commentary. The commentary intends to integrate our study findings and the work of one state that is pioneering the first-ever comprehensive community-based public health approach to suicide prevention.

I believe that both the *Vital Signs* article and the journal companion piece will attract a great deal of attention. This is the debut feature on suicide in a Vital Signs and the results are highly compelling and relevant to a wide public health audience (see description below) including states, prevention practitioners, and providers. In addition, the U.S. Surgeon General has also expressed interest in conducting a town hall meeting as part of the wider release.

BRIEF DESCRIPTION: Suicide rates have increased nearly 30% between 1999 and 2016. To address this serious and growing problem, the proposed *Vital Signs* will use data from the *National Vital Statistics System* (NVSS, 1999-2016) and *National Violent Death Reporting System* (NVDRS, 2015). The trends in suicide rates in the U.S. overall and *by state* and sex, will be reported for the first time. Changes in state rankings over time will also be included. To help the reader fully understand and appreciate the multiple factors influencing suicide risk, the report will also compare the many social and environmental circumstances preceding suicide among people with and without known mental health problems. Preventive solutions will be offered that focus on a comprehensive population-based approach using the best available evidence as described in the CDC's Suicide Prevention Technical Package.

We have selected *AJPH* as our journal of choice for this commentary as we believe its reputation for high quality science and public health prevention most closely aligns with our message and our target audience. We hope that you will partner with us as we forge this exciting territory.

For your convenience, here is an example of a relatively recent Vital Signs (on opioids) and the companion commentary.

I look forward to your reply and the opportunity to provide additional information.

Sincerely,

Deb Stone

Deb Stone, ScD, MSW, MPH
Behavioral Scientist
Suicide, Youth Violence, and Elder Maltreatment Team
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Research & Evaluation Branch
4770 Buford Highway, MS F-64
Atlanta, GA 30341
770.488.3942
dstone3@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 20 Feb 2018 16:55:50 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC)
Subject: RE: CDC Commentary for a June Vital Signs on Suicide

Thanks Tom and Jim,
I'll reach out to CO and thank you for clarifying that the MMWR doesn't need to be cleared (or cross-cleared) to make the editorial happen.
That's a relief!
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 20, 2018 10:23 AM
To: Mercy, James (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: CDC Commentary for a June Vital Signs on Suicide

Hi Deb,
I'm so glad that AJPH is open to this. I think we should start reaching out to colleagues in CO who might be interested in writing this. I think they could simply use the increasing rates in the MMWR as a starting point for the broader discussion about what comprehensive suicide prevention looks like in a state, the role of CDC's technical package, how they are making prevention happen, how they will monitor and sustain it etc.
Our MMWR does not need to be cleared first. We could provide our colleagues who are writing this commentary with a brief description of the key findings and that should be sufficient to get them started.
I don't think cross-clearance will be needed if we keep the focus described above. We won't need to cross-clear with NCHS since we are not presenting new data from Vital Stats in the commentary.
-Tom

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 20, 2018 6:41 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: CDC Commentary for a June Vital Signs on Suicide

This is great Deb. I think this could be worked out. As I understand it this "editorial" would have to parallel and not duplicate the VS MMWR, although you clearly will have to link the two. So need to think of an interesting and captivating way to sort of simultaneously link to the MMWR, but elevate the issue in a different way. Maybe use the editorial to talk about comprehensive suicide prevention or primary directions we should be heading (e.g., comprehensive, social media, etc.).
I don't see why the MMWR has to necessarily be cleared first. Why would we need cross clearance on the "editorial?"
Let me know if there is anything I can do to help.
Thanks,
JIm

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, February 19, 2018 4:45 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>
Subject: FW: CDC Commentary for a June Vital Signs on Suicide

Hi Tom,

The good news is that we got the green light to submit an Opinion Editorial to AJPH (similar format to JAMA Viewpoint). The bad news is that we need to do so by April 5th.
I think we should go forward with this but wouldn't we need a cleared MMWR first? I think we could manage Center clearance but cross-clearance??
Will need to talk this through…
Deb

Opinion Editorials may be commissioned or reformatted as editorials from submitted papers. They are 1200 words of text with subheadings, 1 small table or figure, and no more than 7 references.

From: American Journal of Public Health Editor [mailto:editorajph@qc.cuny.edu]
Sent: Monday, February 19, 2018 2:56 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: CDC Commentary for a June Vital Signs on Suicide

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Sincerely,
Alfredo Morabia, MD, PhD
Editor-in-Chief, AJPH
Twitter | AJPH

From: Morabia, Alfredo <am52@cumc.columbia.edu>
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To: American Journal of Public Health Editor
Subject: Fw: CDC Commentary for a June Vital Signs on Suicide

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To: am52@columbia.edu
Cc: Preventive.Medicine@qc.cuny.edu
Subject: CDC Commentary for a June Vital Signs on Suicide

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I am writing to inquire whether AJPH may be interested in collaborating with us to publish such a commentary. The commentary intends to integrate our study findings and the work of one state that is pioneering the first-ever comprehensive community-based public health approach to suicide prevention.
I believe that both the *Vital Signs* article and the journal companion piece will attract a great deal of attention. This is the debut feature on suicide in a Vital Signs and the results are highly

compelling and relevant to a wide public health audience (see description below) including states, prevention practitioners, and providers. In addition, the U.S. Surgeon General has also expressed interest in conducting a town hall meeting as part of the wider release.

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For your convenience, here is an example of a relatively recent Vital Signs (on opioids) and the companion commentary.

I look forward to your reply and the opportunity to provide additional information.

Sincerely,

Deb Stone

Deb Stone, ScD, MSW, MPH
Behavioral Scientist
Suicide, Youth Violence, and Elder Maltreatment Team
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Research & Evaluation Branch
4770 Buford Highway, MS F-64
Atlanta, GA 30341
770.488.3942
dstone3@cdc.gov

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: 15 May 2018 14:30:24 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: CDC Data Release - County-Level Trends in Suicide Rates & Upcoming MMWG Call (5/31)
Attachments: Suicide VSWG Meeting Notes 5.15.18.docx

Ack – I'm sorry I missed this. I went straight to 2 other meetings after our VS meeting. Here's the most recent verison.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 15, 2018 1:19 PM
To: Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: CDC Data Release - County-Level Trends in Suicide Rates & Upcoming MMWG Call (5/31)

Can you send me the most recent Q&As?
I have until 2:00 to review them. Ugh.
Deb

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 15, 2018 11:59 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: CDC Data Release - County-Level Trends in Suicide Rates & Upcoming MMWG Call (5/31)

Added this to the "recent CDC research" section of the QA doc:

- In mid-May, the National Center for Health Statistics released a study describing county-level trends in U.S. suicide rates from 2005-2015.
  - This study, published in the American Journal of Preventive Medicine, documents that county-level suicide rates increased by more than 10% from 2005 to 2015 in 99% of counties in the U.S.
  - 87% of counties showed an increase of greater than 20%
  - States and communities can use these data in combination with the results from the present study to obtain more granular level detail about suicide rates within their states and to help focus prevention efforts.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 15, 2018 9:54 AM
To: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: CDC Data Release - County-Level Trends in Suicide Rates & Upcoming MMWG Call (5/31)

Hi Kristin,
Yes, they had mentioned this a while ago and that it was in the pipeline with AJPM. We asked and they confirmed that there were no state-specific rates and there would not be a press release. We were not so concerned given that.
Tom

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 15, 2018 9:37 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>

Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: FW: CDC Data Release - County-Level Trends in Suicide Rates & Upcoming MMWG Call (5/31)
Importance: High

Hi Tom,

I'm not sure if you received the email below. Deb and I were both surprised to see that this analysis of county-level trends in suicide rates was released online yesterday. The first author is someone from NCHS, who I don't believe any of us has worked with, but Holly and Margy are also coauthors, so I would have expected to hear about this in our meetings with NCHS. I don't recall them mentioning it in any of our recent meetings, as I think we would have expressed concern over the timing of the release with respect to the VS.

Kristin

P.S. We have a media messaging meeting with this WG scheduled for Thursday where we can let them know the social media post they proposed below is not accurate: Data released by @CDCInjury featured in @AmJPrevMed shows county-level trends in suicide rates in the US http://bit.ly/2IHo6hk

- CDC Injury is not the group that released this data – it's NCHS.

From: Torguson, Kimberly <KTorguson@edc.org>
Sent: Monday, May 14, 2018 6:55 PM
Subject: CDC Data Release - County-Level Trends in Suicide Rates & Upcoming MMWG Call (5/31)
Importance: High

Hello Media Messaging Work Group,

We wanted to call to your attention to a just-released article published in the *American Journal of Preventive Medicine* that looks at county-specific estimates of suicide rates. The paper titled "County-level Trends in Suicide Rates in the U.S., 2005-2015" was written by our Partner, CDC (authors include: Lauren M. Rossen, Holly Hedegaard, Diba Khan and Margaret Warner from NCHS).

Key findings include:

- Posterior predicted mean county-level suicide rates increased by >10% from 2005 to 2015 for 99% of counties in the U.S., with 87% of counties showing increases of >20%.
- Counties with the highest model-based suicide rates were consistently located across the western and northwestern U.S., with the exception of southern California and parts of Washington.
- Compared with more urban counties, more rural counties had the highest estimated suicide rates from 2005 to 2015, and also the largest increases over time.

Overall the data underscores the importance of looking at geographic areas to identify high risk and need for more coordinated and comprehensive community-based suicide prevention efforts in the U.S. While the Action Alliance does notplan to put out a formal statement about the data at this time, we encourage you to reference our past collective statement (written in collaboration with the MMWG partners) released last year that looks at suicide rates in urban and rural areas. You'll notice much of the information is very relevant and timely as it relates to the county-level trends data.

Please find below some tailorable social media posts to help further promote the data:

- Data released by @CDCInjury featured in @AmJPrevMed shows county-level trends in suicide rates in the US http://bit.ly/2IHo6hk
- New article featured in @AmJPrevMed underscores need for coordinated and comprehensive community-based suicide prevention efforts http://bit.ly/2IHo6hk
- Trends about suicide, like geographic patterns, helps us develop more targeted community-based #suicideprevention strategies http://bit.ly/2IHo6hk so we can reduce annual suicide rate 20% by 2025
- Rural counties in the U.S. had the highest estimated suicide rates from 2005-2015 according to just-released @AmJPrevMed http://bit.ly/2IHo6hk

- Tracking county-level suicide rates helps our field to better understand changes in suicide rates over time and develop more targeted suicide prevention efforts http://bit.ly/2IHo6hk
- Together we can reduce the annual suicide rate 20 percent by 2025 but we need continued research on community-level risk and protective factors as shown in recent data by @CDCinjury http://bit.ly/2IHo6hk

When posting, please consider incorporating Media Messaging Work Group Partner Twitter handles:

- @Action_Alliance
- @AASuicidology
- @afspnational
- @CDCInjury
- @CDCMMWR
- @DeptofDefense
- @DeptVetAffairs
- @EDCTweets
- @NIH
- @NIMHgov
- @ReingoldInc
- @samhsagov
- @SAVEvoicesofedu
- @SPRCtweets
- @TrevorProject
- @800273TALK

Some resources that you may also find helpful as you promote the data include:

- **Action Alliance's *Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention*** – A resource that outlines strategic components that should guide program planning and implementation at the community level.
- **CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*** – A resourcethat helps states and communities prioritize efforts to prevent suicide.

We wanted to give you all the heads up that CDC is also expected to release additional relevant data to inform suicide prevention efforts on or around June 5th. The Action Alliance Secretariat does plan to convene this group to develop consensus messaging around this impending data release. In preparation for this larger data release, we'll be convening the MMWG for a call in late May to discuss the data and our collective statement.

REQUEST: Please join us for a planning call on Thursday, May 31 at 2:00 p.m. ET to plan ahead for collective statement about CDC data.

We will send you a calendar invite (containing call-in information) to you shortly. If you are unable to participate on this call, you'll have the opportunity to weigh in on the statement electronically.

Lastly, we wanted to thank CDC for giving us the heads up about the data.

Thank you.

Kimberly Torguson
Associate Director for Communications
National Action Alliance for Suicide Prevention
Email: ktorguson@edc.org | Phone: 202-572-3737
Follow us: Twitter | Facebook


NATIONAL
ACTION
ALLIANCE
FOR SUICIDE PREVENTION

SUICIDE VITAL SIGNS WORK GROUP MEETING

MAY 15, 2018

10A/877-324-1610, (b)(6)
12 noon – 1:00
Note taker: Kristin

Pre-Brief with Dr. Schuchat, Tuesday, May 8th, 1-1:45 ✓

Agenda

- **Set up & welcome** (Deb; **5-10 mins**)
- **Monday's curve ball**
  - **Change from "mental health problems" to "mental health conditions"**
  - **Comms products, FS, and MMWR have all been updated with this language**
    - **Social media, telebriefing script, press release**
    - **Did You Know items will be pulled from the FS**

- **Recap from last week's pre-brief + new updates, next steps**
  - **Pre-brief debrief** (Attendees & Deb; **10 mins**)
  - Next steps (see attached table)
    -

  - **MMWR status** (Deb**; 5 mins)**
  - Next steps (what's on the horizon)
    - Deb rec'd first proof on Friday
      - Revisions were due 8am on Monday – complete
    - Deb rec'd additional reviewer comments from first proof on Monday
      - Revisions submitted on Monday – spoke with Theresa on the phone
    - Deb rec'd second proofs yesterday late in the day
      - Revisions due by 1:00 today
        - Will review the tables again because of concern over double set of proofs
          - A few changes had been made to indentations and bolding of overarching categories
            - E.g., mental health conditions need to be indented
          - Kristin will help with this review
    - Should receive third set of proofs tomorrow
      - Tables need to be reviewed by Friday
      -

  - **Fact Sheet** (Deb; **5 mins)**
  - Next steps
    - Changes to "everyone can" section
    - Changes to page 3 consistent with best practices for media

- Graphic design elements
  - Crystal will coordinate with Molly
- Tom will take first pass and forward to Deb and Kristin

➢ Next version due back to VS team 5/16 COB

➢ **Communication products** (Crystal & Kristin (Q&A); 5 **mins)**

➢ Next steps
- Press release – with VS team
- Critical contacts, dear colleague letter – with VS team
- Social media
  - Pulled directly from FS, but social media team came back with changes
    - Substance abuse – change to "substance use"
    - Will send those to Tom
- Q&A – with Kristin; will send to Deb to review
  - Needs to be submitted to VS team by COB today
- Telebriefing introduction – wording is "Suicide: More than just a MH condition"
- Script – talking points received from Surgeon General yesterday afternoon
  - Need to review – Crystal will send to the group
  - Crystal will put these TPs into the overall script and send the script back out
- Outstanding pieces: Q&A, script, media advisory

➢ **Policy/Partnerships** (Erin; **5 mins)**

➢ Next steps
- Town Hall – June 12
  - Need to identify state examples
    - Colorado should be one
    - Malia can reach out to Ellie at SPRC to get another example
    - Malia will formulate email for Jarrod and Deb will send it
      - The ask will be to do a presentation – need to pull together talking points and slides – we need them by June 1
    - Second state suggestions: NC, MA, TX
      - State health dept seems to be involved
  - Who does this involve?
    - Deb has 8 mins to present, state speakers
    - We can all call in at 2:00 on this day
- Malia has list of partners on board
  - ASTHO CEO will participate in Twitter chat
  - Will take part in NVDRS call to give them a heads up
  - Will talk to DARPI about how to prime CoreSVIPP grantees
  - Congressional plan – hill alerts to every congressional office
    - Hill visits June 7 and 8 – Deb H. and Jim
    - Will do some other Hill visits in September
  - AFSP Policy Summit – June 11
    - Will be there for that briefing (Alex)
  - Erin working with NGA – webinar for policy health advisors in July

- Blog post for national Conference of State Legislators
- Template language for all of our partners – newsletter blurb, customized emails from Jim and Deb for them to send on June 7th – linking VS to priorities

➢ June 7 – press briefing – Deb will be there with Dr. Schuchat

➢ **Other items** (Deb/everyone; **15-20 mins**)
  - ➢ **Town hall**
  - ➢ **Continuing education**
  - ➢ **Science clips**

➢ **Next steps/meeting/Wrap-up** (Deb; **5 mins**)

Next VS Due Dates:

- **To be provided in updates above**



What we need to get moving on ASAP!

- **Town Hall – Need to nail down participant list by end of the week**

Continuing education – candidate questions so people can get CEUs

From: Chris Maxwell
Sent: 7 Jun 2018 13:38:43 +0000
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Re: CDC Report

Hi Malia,

I greatly appreciate you sending these over and I totally understand about the strict limits put on sensitive information.

Thanks again and I hope you have a wonderful rest of the week.

Take care,

Chris Maxwell
Communications Coordinator
American Association of Suicidology
5221 Wisconsin Ave, NW
Washington, DC 20015
Office: 202-237-2280 ext. 306
Cell: 913-775-2293

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

> On Jun 7, 2018, at 8:36 AM, Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov> wrote:
>
> Chris,
> Thank you very much for reaching out. Deb shared your email with me as I'm helping with outreach related to the Vital Signs launch. Embargoed copies of the report and associated materials are attached. Please do not share this information with your networks until the embargo lifts **at 1pm today.** Some additional information is below on events – telebriefing for media, social media tools and Town Hall teleconference next week.
> I'm so sorry we weren't able to share these materials with you sooner so that it would have helped with media inquiries. We were under a strict embargo and are only allowed to share even embargoed copies beginning at this morning. Please let me know if I can answer any questions or help in anyway moving forward.
> Best,
> Malia
> The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide

prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Web page to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST). *Vital Signs* is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Malia Richmond-Crum, MPH
Team Lead, Policy and Partnerships
Division of Violence Prevention
National Center for Injury Control and Prevention
Centers for Disease Control and Prevention
Office: 770-488-0526 | Cell: 404-307-6135
mrichmondcrum@cdc.gov

From: Chris Maxwell <cmaxwell@suicidology.org>
Sent: Thursday, June 7, 2018 9:27 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: CDC Report

Hi Deb - hope you're doing well!

We've been contacted by some members of the press over the past couple of days due to the recent and unfortunate celebrity suicide and a few of them have been referencing the yet-to-be-released report coming out today regarding suicide and NVDRS data.

Would it be possible for our Executive Director and President to receive drafts or embargoed advance copies of these types of reports so they can be better prepared to answer the questions from the media? This could go a long way in helping both our membership and the general public be more prepared to handle inquiries from the media, especially when the media has been provided advance notice or data.

If we need to contact someone else over there, please let us know who we should get in touch with.

Thanks and looking forward to hearing from you!

Chris Maxwell
Communications Coordinator
American Association of Suicidology
5221 Wisconsin Ave, NW
Washington, DC 20015
Office: 202-237-2280 ext. 306
Cell: 913-775-2293

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

From: Hindman - CDPHE, Jarrod
Sent: 4 Jun 2018 14:52:58 -0600
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Subject: Re: CDC Suicide Vital Signs Town Hall: Request for bio, photo and PPT slides
Attachments: 2018-06-12-CDC-Hindman.pptx

See attached. Happy to update the data, but am not totally sure what the Vital Signs will have us ranked at. I'm fine changing the talking point to something like, "2014-2016 - ? highest rate in nation according to Vital Signs report".

I deleted slide #2 rather than combining 11 and 12.

JH

On Mon, Jun 4, 2018 at 2:22 PM, Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov> wrote:

> Thanks Jarrod. A couple of edits:
>
> Slide 3
>
> • The L in Laws should be capitalized to be consistent with the rest of the table
>
> • Data point about Colorado rate being 5th in the nation is inconsistent with the state data which will be reported through Vital Signs because that combines multiple years (2014-2016) and results in a slightly different ranking. You could keep as is, but I just want you to be aware b/c it may look a little off so you may have to address in talking points.
>
> Slide 8: typo in home-base
>
> Slide 11 and 12 – is it possible to combine these? We're kept to a strict slide limit of 12 and your last slide should include your contact info so we'll need a new Slide 12 that has that info.
>
> Malia
>
> **From:** Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us>
> **Sent:** Monday, June 4, 2018 2:57 PM
> **To:** Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
> **Cc:** Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
>
> **Subject:** Re: CDC Suicide Vital Signs Town Hall: Request for bio, photo and PPT slides

Sorry for the delay. Please let me know what edits you'd like to the attached. On Friday, I'm open anytime after Noon EDT as well.

Jarrod

On Mon, Jun 4, 2018 at 10:58 AM, Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us> wrote:

> Sorry, I just noted your email. I will be in meetings until 12:30pm my time, so can't get you slides until after that. I did not note the "Monday morning" part of your request. I will have them to you by COB today.
>
> I have time for a call this Friday. Let me know some possible times. Thanks.
>
> Jarrod
>
> On Mon, Jun 4, 2018 at 8:05 AM, Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov> wrote:
>
> > Hi Jarrod
> >
> > I hope your conference went well last week. We're looking for to receiving your slides this morning. Please let me know if you have any questions or need anything today.
> >
> > Also we would like to schedule a run through with you and Neetha on the phone on Friday – we're free anytime after Noon ET on Friday works for us. Please let me know your availability that day and I will send a meeting invite.
> >
> > Best,
> >
> > Malia
> >
> > **From:** Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
> > **Sent:** Friday, June 1, 2018 3:16 PM
> > **To:** Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us>
> > **Cc:** Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
> > **Subject:** RE: CDC Suicide Vital Signs Town Hall: Request for bio, photo and PPT slides
> >
> > Jarrod
> >
> > I hope your conference went well. I just wanted to share the attached FAQs for Town Hall speakers in case this is helpful as you finalize your slides and send to us on Monday morning.
> >
> > Have a good weekend.
> >
> > Malia

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 12:57 PM
To: Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: RE: CDC Suicide Vital Signs Town Hall: Request for bio, photo and PPT slides

Hi Jarrod,

I think what you mention is great. If you want me to check out the slides first to verify, happy to do so!

Deb

From: Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us>
Sent: Wednesday, May 30, 2018 9:02 AM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: CDC Suicide Vital Signs Town Hall: Request for bio, photo and PPT slides

Yes, I can meet that timeline. Thank you. So I'm clear, do you want me to focus on our strategies and priorities related to the CO-Nat'l Collaborative and our comprehensive approach? If so, it should be relatively simple to get you draft slides no later than Monday morning. Thank you.

Jarrod

On Tue, May 29, 2018 at 1:55 PM, Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov> wrote:

> Hi Jarrod – Would you be able to send your slides to us no later than Monday morning (June 4)? We really can't push it back any more than that I'm afraid.
>
> I'm hoping this is not too big an ask and that you might already have slides from previous presentations that cover's Colorado's comprehensive approach to suicide prevention – though I totally understand when your travel, presenting at conferences etc. it can be hard to get other work done.
>
> Malia
>
> **From:** Hindman - CDPHE, Jarrod <jarrod.hindman@state.co.us>
> **Sent:** Friday, May 25, 2018 5:39 PM
> **To:** Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
> **Cc:** Mony, Neetha E (DOH) <neetha.mony@doh.wa.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
> **Subject:** Re: CDC Suicide Vital Signs Town Hall: Request for bio, photo and PPT slides

Hi Malia -

Photo and bio attached. Unfortunately, I am completely booked on Tuesday, which is my only day in the office next week. I'll be at a conference Wed through Fri, which also means it will be very difficult for me to get you slides by next Wed. Is there any flexibility? Sorry for the wrench and certainly let me know if that impacts my participation.

Jarrod

On Thu, May 24, 2018 at 3:44 PM, Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov> wrote:

> Neetha and Jarrod,
>
> Thank you again for agree to participate in the June 12 Vital Signs Town Hall - *Suicide Rates Rising Across the US.* We're very excited to have you participate and showcase the wonderful prevention work you're doing in Washington and Colorado respectively.
>
> I have a couple of requests:
>
> 1. Would you please send a short (1-2 paragraph) bio and photo to me **by COB Friday**?
>
> a. This info will be posted on CDC's website (see https://wwwdev.cdc.gov/stltpublichealth/townhall/2018/5-may.html)
>
> 2. I would like to schedule a 30 minute conference call with you both to discuss the Town Hall logistics. Here are some dates/times, please let me know your availability.
>
> o Friday May 24 (tomorrow): 12-4:30pm ET
>
> o Tuesday May 29: 12:00-4:30pm ET
>
> o Wednesday, May 30: 12:00-4:30pm ET
>
> 1. Lastly, I would like to request your Powerpoint slides be sent me **no later than Wednesday, May 30**. I apologize for the tight timeline and asking for them so far in advance of the Town Hall. Please let me know if the May 30 deadline is a problem.
>
> a. You'll be speaking for 10 minutes and your PowerPoint presentation should be no more than 8 to 12 slides(slide limits are strictly enforced).

- First slide should be a title slide with the name of presentation, presenter name, credentials, organization, and position.
- Last slide should include presenter contact information
- All of acronyms are spelled out at the first instance.
- Slides should be material that is ready to be public facing

Thank you again!

Best,
Malia

Malia Richmond-Crum, MPH

Team Lead, Policy and Partnerships

Division of Violence Prevention

National Center for Injury Control and Prevention

Centers for Disease Control and Prevention
Office: 770-488-0526 |Cell: 404-307-6135

mrichmondcrum@cdc.gov



Preventing Injuries and Violence
Through Science and Action

--

Jarrod Hindman, MS

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COLORADO NATIONAL COLLABORATIVE FOR SUICIDE PREVENTION

COLLABORATIVE, DATA-DRIVEN, PUBLIC HEALTH APPROACH TO REDUCE COLORADO SUICIDE DEATHS 20 PERCENT BY 2025



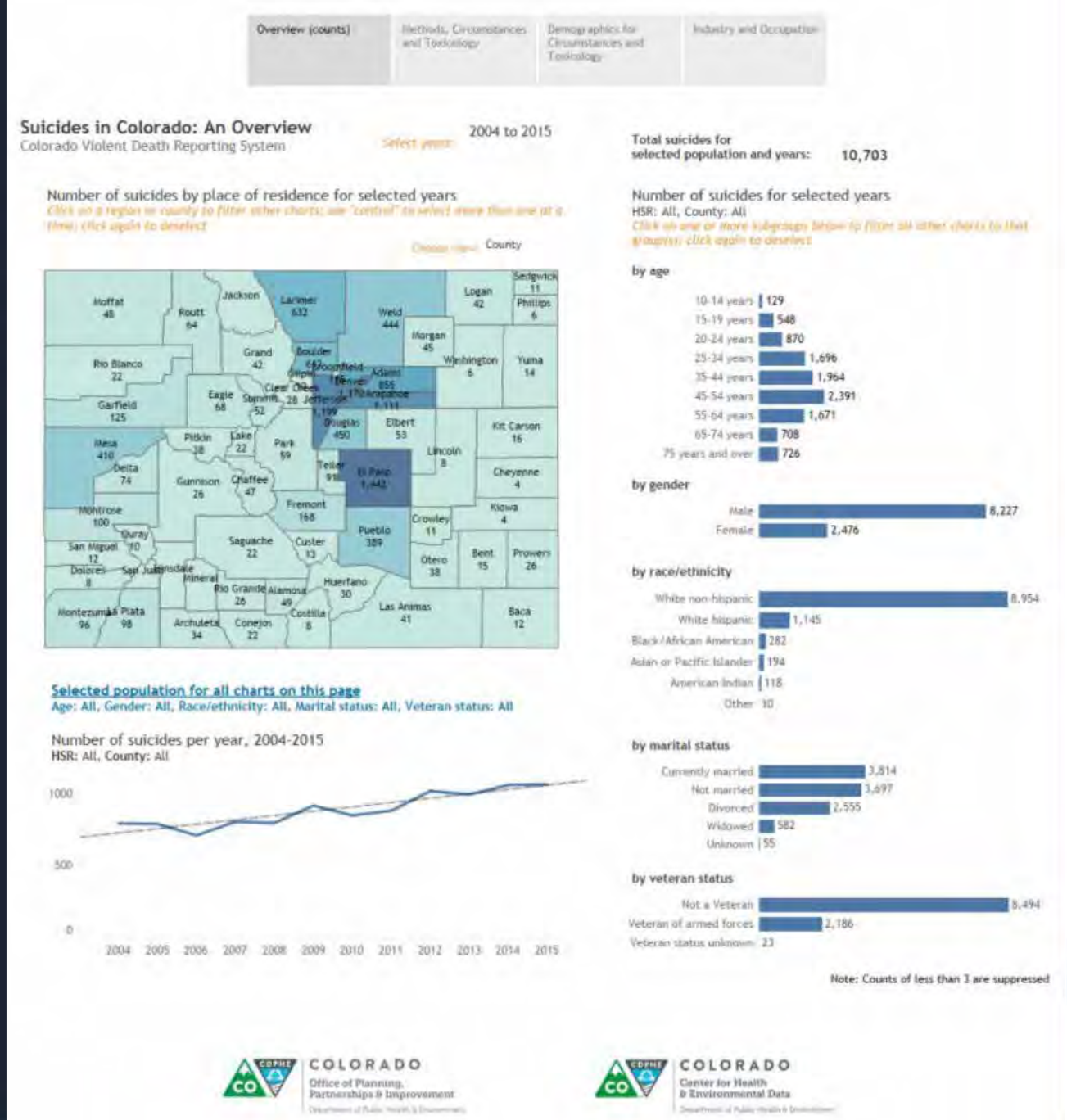
Jarrod Hindman, MS: Violence and Injury Prevention – Mental Health Promotion, Colorado Dept of Public Health & Environment

Identifying the Starting Point: State Readiness

Factors	Evidence
Significant Burden	• High enough burden to demonstrate effectiveness of successful intervention2016 - 1,156 deaths; 20.87 per 100,000 residents2016 - 5th in the nation
Political Will	• Senior political support (e.g. governor & state legislature)Recently passed legislation in support of suicide prevention
Key Infrastructure	• Senior Executive & State InfrastructureSuicide Prevention CommissionSupport across federal, county, & community behavioral health centers
Firearm Laws	• Preferred state with less restricted rural/urban firearm ownership laws
Agreement on Approach	• Respect for both Upstream & Downstream Approaches (Public Health & Mental Health)

Establishing Priorities: An Interactive Data Dashboard

https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/CoVDRS_12_1_17/Story1?:embed=y&:showAppBanner=false&:showShareOptions=true&:display_count=no&:showVizHome=no#8



Establishing Priorities: Health Care

Zero Suicide

Priority Systems:Mental Health / Behavioral HealthIntegrated CareEmergency DepartmentsHospitalsPrimary Care (#1 priority for older adults)VA / DoDDepartment of Corrections

Establishing Priorities: Youth

Primary PreventionShared Risk and Protective Factors

Priority Populations and Systems:Schools (including parents)Community programs and resources serving youthDepartment of Youth CorrectionsCourts, foster care, child welfareMilitary familiesEarly childhood programs and systemsHispanic/Latino youthLGBTQ youthFaith communities

Establishing Priorities: Adults

Means SafetyPublic Awareness / Social Norms ChangePolicy

Priority Populations and Systems:Veterans, particularly non-VHA veteransHigh risk industriesCourts and criminal justice systemsFinancial services systems (unemployment, bankruptcy, etc.)

Establishing Priorities: Older Adults

Primary Care (Zero Suicide)Existing Community ServicesConnectedness

Priority Systems and Services:Social services agenciesSeniors centersAssisted living facilitiesActive living servicesDeath and dying servicesFaith communityVietnam era veteransPublic service providers (transportation, meals on wheels, store clerks, etc.)Falls preventionHome-based care and servicesPain management

Environmental Scan

A mapping of existing efforts to prevent self-injury mortality. Participants include health systems, prison systems, government agencies, community-based organizations engaged in prevention efforts.

Which Suicide-related Activities Are Happening?



Who do you serve? In what setting?



How are your prevention efforts funded? How long do you expect your funding to continue?



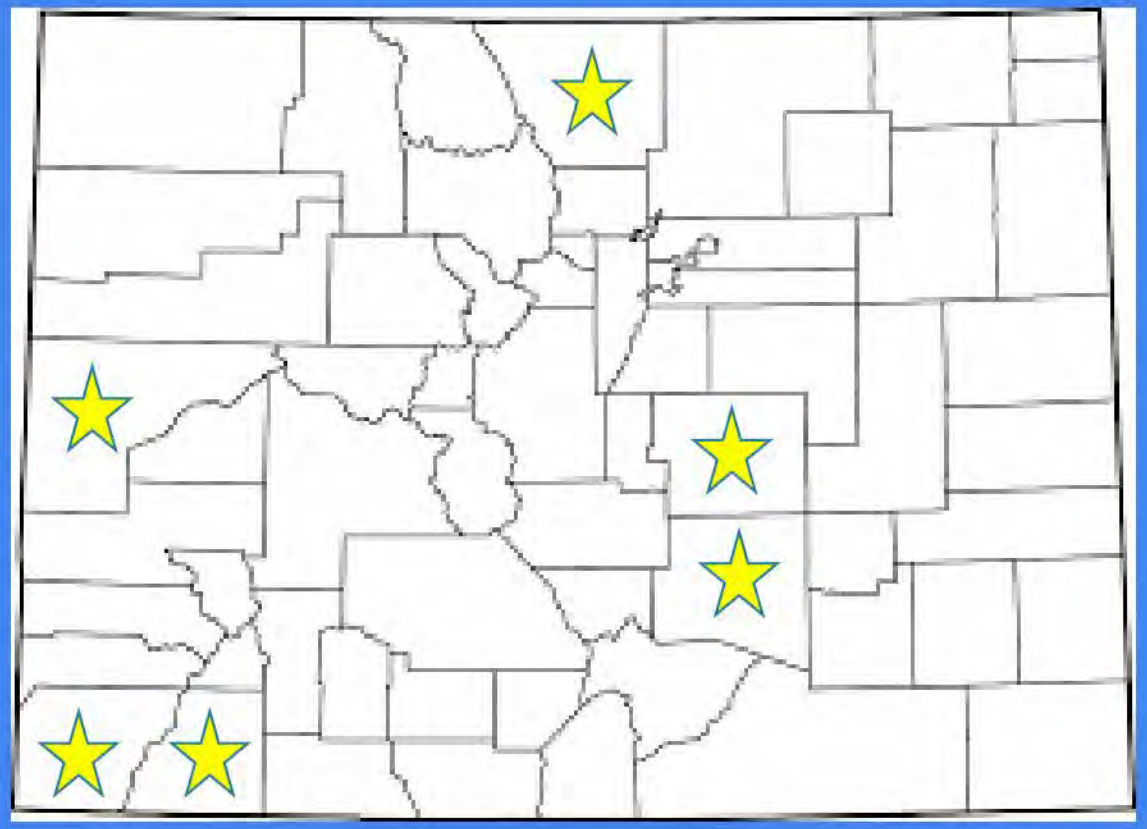
Do you collaborate with other prevention agencies? Who are your important collaborators?

Evaluation

Intervention Packages / ProgramsProcess and outcome designs to measure baseline and impact of all intervention strategies, programs, and/or policiesAction Research / Systems LevelTracking and measuring the processEnsuring that successes can be accounted for and replicated in additional communitiesNational partners – Ensure that strategy can be replicated in other statesConstant EvolutionIterative Design

Local Partners & Priorities

1) Environmental Scan of Counties w/ Highest BurdenEnhance / Build Local PartnershipsTarget Focal Populations: Youth, Adults, Older Adults: Criminal Justice, Veterans outside of VA, High-risk Industries



State and National Partners

1) Steering teamImplementation teamEvaluation teamExpert guidance and capital

Colorado:Office of Suicide PreventionSuicide Prevention CommissionGovernor's OfficeDenver VAUniversity of Colorado Colorado Behavioral Healthcare CouncilOther state agenciesNational:Suicide Prevention Resource CenterInjury Control Research Center for Suicide Prev.Centers for Disease Control and PreventionAmerican Foundation for Suicide PreventionNational Action AllianceSubstance Abuse and Mental Health Services Administration

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 31 May 2018 17:46:05 +0000
To: Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: CDC Vital Signs Telebriefing June 7th

Hi Crystal,
Sorry for delay. Yes, that's the last one I have too. Will respond to your other email shortly.
Deb

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Thursday, May 31, 2018 11:31 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: FW: CDC Vital Signs Telebriefing June 7th

Deb,
I think you were the last person working on the telebriefing script (correct me if I'm wrong). I don't want to send the wrong version to Dr. Schuchat office. Here's what I'm sending, unless you have a later version...
Crystal

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 31, 2018 11:02 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: CDC Vital Signs Telebriefing June 7th

FYI, just heard from Lynn that we need the revised telebriefing script by 10AM tomorrow to send to Dr. Schuchat. Let me know status of SG as soon as you're able.

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 6:40 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: Re: CDC Vital Signs Telebriefing June 7th

Dr. Schuchat's preference is to do the telebriefing solo but to give the SG's office some content (TPs, etc.) to promote via social media or other messaging of their choice on their own schedule.
If this is ok with you all, I think we're ok to communicate this back to the SG's office.

From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Sent: Wednesday, May 30, 2018 5:20 PM
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>, Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>, Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>, Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>

Thanks for looping in Deb H, Leslie. Will wait to hear back. If the SG doesn't work out, Lynn suggested he could put out a written statement, just FYI.
Deb

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 4:12 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

Got it. Will keep you posted!

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 4:11 PM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

I share that concern about the ASH. There could be a risk in bringing that office in at this point.

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 4:09 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

Chatted with Deb. She's open to the SG doing a statement or even the ASH doing a brief call topper. We're both a little worried about the ASH focusing more on the HHS priority angle of severe mental illness vs. our 'more than mental illness' approach though. She's going to email Dr. Schuchat this evening and see if she wants to weigh in.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 4:00 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

Hi Leslie,

Thank you for sharing your perspective – this is very helpful. I welcome Deb H's thoughts on this. I think a supportive message from the SG about the urgency of the issue and the need for a public health approach will be very helpful – even if it is recorded or a media statement. Him making the time to do this sends a message too. If that won't work then I agree just Dr. Schuchat at the briefing.

-Tom

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Wednesday, May 30, 2018 3:54 PM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

Got it! Thanks for your guidance!!

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 3:52 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

Adding Tom back in because I accidentally deleted him. I checked in with Lynn on how to come to a decision on this. She recommended we make a rec and then loop in Dr. Schuchat since HHS leadership is involved. (I can get Deb's thoughts too on this…) Lynn recommended Deb email Schuchat with our rec.

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Wednesday, May 30, 2018 3:51 PM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

Thanks Leslie, these are very good points! At what point to we say to the SG's office "Thanks but, we've got this." I know they are trying to find a way for him to participate, but logistically it's just not working out. When do we make the call and who does that?
Crystal

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 3:45 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

I'm just including NCIPC folks on this email (deleting VS folks).
My two cents is that if the SG cannot do it, then perhaps we could suggest he could put out a supportive media statement or something? I think journalists would find a recorded message on a live telebriefing quite atypical. I also think involving the ASH at this point will be probably difficult. Deb, Schuchat, and OPP have been working closely with him on the opioid issue and he has high demands for information, quick turnaround asks, is very exacting in his questions/comments—all completely within his purview—but I just think it would be hard to manage this in the final stretch of a VS and I worry that he would shift our messaging potentially. (Plus, media visibility-wise, the SG has more pull than the ASH, so I don't know that swapping them out is really as appealing for a journalist.)
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Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC)

<fus3@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

One thing to consider is that the SG has spoken on suicide and does a great job. Reporters might appreciate having some quotes from him that they can use – even from a recorded message. It could help raise the profile of the release.

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Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

We've never done that with a speaker. Since this is an audio telebriefing, it might not sound real, since Anne will be "live". We also pre-brief 20-mins before, which he would miss. Is there a conflict?

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Subject: FW: RE: CDC Vital Signs Telebriefing June 7th

Any thoughts? I'm headed to a meeting; happy to discuss
Crystal

From: Migliaccio-Grabill, Kate (HHS/OASH)
Sent: Wednesday, May 30, 2018 11:17 AM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

Hi,
Is it possible to tape the SG's remarks?
Kate Migliaccio Grabill, MPH
CDR, USPHS
Press Secretary

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Sent: Tuesday, May 29, 2018 11:01 AM
To: Migliaccio-Grabill, Kate (HHS/OASH)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC); Black, Erin (CDC/ONDIEH/NCIPC); Ballman, Marie R. (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Peaker, Brandy (CDC/OPHSS/CSELS/DPHID); Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

Hi Kate,
We are so glad to hear that! Having Dr. Adams on the call will be an important part of the telebreifing.
Crystal

From: Migliaccio-Grabill, Kate (HHS/OASH)
Sent: Tuesday, May 29, 2018 10:57 AM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

Hi Crystal,
Actually, I think we can make this work.
Kate Migliaccio Grabill, MPH
CDR, USPHS
Press Secretary

From: Migliaccio-Grabill, Kate (HHS/OASH)
Sent: Tuesday, May 29, 2018 10:12 AM
To: Bruce, Crystal (CDC/OPHPR/OD)
Subject: Re: RE: CDC Vital Signs Telebriefing June 7th

Hi,
We have a quick question for you.
Is it possible to change the date? If not, would you be up for having the ASH stand in?
It's going to be really hard to have the SG take this from the airport. He's flying back that day from Dallas.

On: 24 May 2018 15:39,
"Bruce, Crystal (CDC/OPHPR/OD)" <jgx6@cdc.gov> wrote:

Hi Kate,
Thanks for the update on the talking points! Our Vital Signs office says the airport call will be fine. We will look for comments on the talking points from Dr. Adams as soon as he can get to them. We appreciate you working with us on this!!!
Respectfully,
Crystal Bruce, MPH
Health Communications Specialist
Detailed to National Center of Injury Prevention and Control
Division of Violence Prevention, Health Communications Team
Office: 770-488-5651
Mobile: 470-249-3616
Cbruce2@cdc.gov
Off alternate Fridays

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: 31 May 2018 11:18:12 -0400
To: Black, Erin (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC)
Subject: RE: CDC Vital Signs Telebriefing June 7th

Thanks, yeah, we need a final decision today. More than happy to provide them with content so he could support via a media statement or social media promo.

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 31, 2018 11:15 AM
To: Bruce, Crystal (CDC/OPHPR/OD)
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) ; Dorigo, Leslie (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC)
Subject: RE: CDC Vital Signs Telebriefing June 7th

I just talked to Leslie and she asked that you please follow-up with the SG's office and let them know we are unable to reschedule or tape Dr. Adam's comments and thus Anne will proceed with hosting the vital signs release.

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Thursday, May 31, 2018 11:07 AM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: CDC Vital Signs Telebriefing June 7th

Leslie…Do you recommend I reach back out to Kate at the SG's office? The last word I had was that she would circle back to me today when she had more details. How pushy should I be?

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 31, 2018 11:02 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: CDC Vital Signs Telebriefing June 7th

FYI, just heard from Lynn that we need the revised telebriefing script by 10AM tomorrow to send to Dr. Schuchat. Let me know status of SG as soon as you're able.

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 6:40 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: Re: CDC Vital Signs Telebriefing June 7th

Dr. Schuchat's preference is to do the telebriefing solo but to give the SG's office some content (TPs, etc.) to promote via social media or other messaging of their choice on their own schedule.
If this is ok with you all, I think we're ok to communicate this back to the SG's office.

From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Sent: Wednesday, May 30, 2018 5:20 PM
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>, Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>, Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>, Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>

Thanks for looping in Deb H, Leslie. Will wait to hear back. If the SG doesn't work out, Lynn suggested he could put out a written statement, just FYI.
Deb

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 4:12 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th
Got it. Will keep you posted!

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 4:11 PM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th
I share that concern about the ASH. There could be a risk in bringing that office in at this point.

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 4:09 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th
Chatted with Deb. She's open to the SG doing a statement or even the ASH doing a brief call topper. We're both a little worried about the ASH focusing more on the HHS priority angle of severe mental illness vs. our 'more than mental illness' approach though. She's going to email Dr. Schuchat this evening and see if she wants to weigh in.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 4:00 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th
Hi Leslie,

Thank you for sharing your perspective – this is very helpful. I welcome Deb H's thoughts on this. I think a supportive message from the SG about the urgency of the issue and the need for a public health approach will be very helpful – even if it is recorded or a media statement. Him making the time to do this sends a message too. If that won't work then I agree just Dr. Schuchat at the briefing.
-Tom

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Wednesday, May 30, 2018 3:54 PM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

Got it! Thanks for your guidance!!

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 30, 2018 3:52 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>
Subject: RE: RE: CDC Vital Signs Telebriefing June 7th

Adding Tom back in because I accidentally deleted him. I checked in with Lynn on how to come to a decision on this. She recommended we make a rec and then loop in Dr. Schuchat since HHS leadership is involved. (I can get Deb's thoughts too on this…) Lynn recommended Deb email Schuchat with our rec.

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CDR, USPHS
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Respectfully,

Crystal Bruce, MPH
Health Communications Specialist
Detailed to National Center of Injury Prevention and Control
Division of Violence Prevention, Health Communications Team
Office: 770-488-5651
Mobile: 470-249-3616
Cbruce2@cdc.gov
Off alternate Fridays

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: 27 Jun 2018 10:32:58 -0400
To: Rebecca Ray
Cc: Walt Hadikin;Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: CDC Vital Signs: Rising Suicide Rates Across the US

Hi Rebecca –

1) "between" is fine for first bullet
2) We're ok with following your style guide re: abbreviations.

Looking forward to the posting. As always we are so appreciative of your help in spreading VS important messages.
In partnership,
Brandy

From: Rebecca Ray
Sent: Tuesday, June 26, 2018 7:04 PM
To: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Cc: Walt Hadikin ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: CDC Vital Signs: Rising Suicide Rates Across the US

Hi Brandy,
Thank you for checking with the subject matter experts. We are happy to use the phrase "Data from 27 states" to make the sentence more accurate, as well as a shortened version of the first bullet. However, in the first bullet, we think it would be better to say "transitions… between providers/settings," vs. "transitions… in providers/settings," since people generally say that transitions occur *between* two different entities.
I understand your concern about the abbreviations—especially since I'm not a clinician myself. If we change "incr" to "increase," we can still stick to the 900-character limit. However, we have to preserve the rest of the abbreviations, since spelling them out would put us over the limit. Also, the abbreviations have been part of our company's unique style since its inception, and we use them throughout our Rx content, as well as in every DocAlert message that would otherwise run too long, so most of our readers are familiar with them.
We will send you the screenshots of the message once it is published.

Rebecca Ray
Senior Associate
Content Editor, Medical Information
San Jose, CA
617.321.0734

athenahealth

Cloud-based services for medical groups and health systems.

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Sent: Tuesday, June 26, 2018 1:47 PM
To: Rebecca Ray <rray@athenahealth.com>
Cc: Walt Hadikin <whadikin@athenahealth.com>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: CDC Vital Signs: Rising Suicide Rates Across the US

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No problem. Thanks!

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Content Editor, Medical Information
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Sent: Thursday, June 07, 2018 7:12 AM
To: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: CDC Vital Signs: Rising Suicide Rates Across the US

Embargoed until today, June 7, 2018 at 1:00 pm EDT

Dear Healthcare Partner:

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EDT) following a media telebriefing at noon; all attached materials are EMBARGOED until 1:00 pm EDT.**

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Thursday, June 7, at 12:00 p.m. ET

Dial-In

Media: 888-795-0855

Non-Media: 800-369-1605

INTERNATIONAL: 1-630-395-0331

PASSCODE: (b)(6)

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
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Healthcare systems can:

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After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpageto find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EDT).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Thank you for your support.

Brandy L. Peaker, MD, MPH
LCDR, U.S. Public Health Service
Deputy Director, CDC *Vital Signs*
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention
1600 Clifton Rd. MS E-90, Atlanta, GA 30333
E: bpeaker1@cdc.gov; O: (404)498-6705; BB: (678)641-7037; F: (404) 498-6055

CDC Vitalsigns

www.cdc.gov/vitalsigns

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To: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
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I am ok with this approach. Thank you for your help!
-Tom

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Center for Surveillance, Epidemiology, and Laboratory Services
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1600 Clifton Rd. MS E-90, Atlanta, GA 30333
E: bpeaker1@cdc.gov; O: (404)498-6705; BB: (678)641-7037; F: (404) 498-6055

CDC Vitalsigns

www.cdc.gov/vitalsigns

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Rebecca and Walt - please see revisions from our SMEs. This was a big one for us as you can imagine. Made front page of NYT, WSJ, and USA Today. Let us know if revisions make Doc Alert too long. Also picture is OK for us.
Thanks,
Brandy

From: Rebecca Ray <rray@athenahealth.com>
Sent: Tuesday, June 12, 2018 7:51 PM
To: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Cc: Walt Hadikin <whadikin@athenahealth.com>
Subject: RE: CDC Vital Signs: Rising Suicide Rates Across the US

Hi Brandy,
Thank you for sending us the latest *Vital Signs* report. We have attached the draft of our DocAlert message for your expert review. In keeping with our new practice of more image-rich DocAlert messages, we have included an image from our stock-photo account; however, if you object to it for any reason, don't hesitate to let us know!
Thank you in advance for reviewing this. Please let us know if you have any questions.

Rebecca Ray
Senior Associate
Content Editor, Medical Information
San Jose, CA

617.321.0734

athenahealth

Cloud-based services for medical groups and health systems.

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Sent: Thursday, June 07, 2018 7:12 AM
To: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: CDC Vital Signs: Rising Suicide Rates Across the US

Embargoed until today, June 7, 2018 at 1:00 pm EDT

Dear Healthcare Partner:

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EDT) following a media telebriefing at noon; all attached materials are EMBARGOED until 1:00 pm EDT.**

CDC Telebriefing – New Vital Signs Report – Suicide Prevention(https://www.cdc.gov/media/releases/2018/a0607-vs-suicide-prevention.html)

Thursday, June 7, at 12:00 p.m. ET

Dial-In

Media: 888-795-0855

Non-Media: 800-369-1605

INTERNATIONAL: 1-630-395-0331

PASSCODE: (b)(6)

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

Healthcare systems can:

• Provide high-quality, ongoing care focused on patient safety and suicide prevention.
• Make sure affordable and effective mental and physical healthcare is available where people live.

• Train providers in adopting proven treatments for patients at risk of suicide.

Helpful tools:

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

National Suicide Prevention Lifeline
Talk: 1-800-273-TALK (8255)
Chat: www.suicidepreventionlifeline.org

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpageto find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EDT).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Thank you for your support.

Brandy L. Peaker, MD, MPH
LCDR, U.S. Public Health Service
Deputy Director, CDC *Vital Signs*
Center for Surveillance, Epidemiology, and Laboratory Services
Centers for Disease Control and Prevention
1600 Clifton Rd. MS E-90, Atlanta, GA 30333
E: bpeaker1@cdc.gov; O: (404)498-6705; BB: (678)641-7037; F: (404) 498-6055

CDC Vitalsigns

www.cdc.gov/vitalsigns

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 8 Jun 2018 17:13:47 +0000
To: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Subject: RE: CDC VS inquiry

Hi Courtney,
I know this is a bit confusing and I'm so sorry about that.

(b)(5)

Either statistic is correct but *if referring to our study specifically, you should say 25% increase.*
Hope this helps.
Deb

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 1:07 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Re: CDC VS inquiry

Deb, I think this is correct, but please confirm.
Sent from my BlackBerry 10 smartphone.

From: Grusich, Katherina (Kate) (CDC/OD/OADC)
Sent: Friday, June 8, 2018 1:04 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Subject: RE: CDC VS inquiry

So just to confirm – the 28 percent overall increase is for all 50 states/nationwide?

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 7:09 PM
To: Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>
Subject: Re: CDC VS inquiry

Hi Kate!

(b)(5)

From: Grusich, Katherina (Kate) (CDC/OD/OADC)
Sent: Thursday, June 7, 2018 6:13 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Subject: CDC VS inquiry

Hey Courtney,
Apologies if this answer is obvious but I'm out of the office and having a hard time accessing materials by phone.
Do we have an actual estimate for the overall national increase between 99 and 2016? I know (b)(5) but CBS appears to be looking for all US stat.
Please let me know recommended response.
Thanks!

From: Birnbaum, Amy <AMB@cbsnews.com>
Date: June 7, 2018 at 6:02:51 PM EDT
To: Grusich, Katherina (Kate) (CDC/OD/OADC)

Hi Kate: Another team did this story for the Evening news, so I didn't hear the telebriefing. Would you mind clarifying what the overall rate of suicide increase is in the us since 1999 as I can't find that in the report.

(b)(5)

From: Knuth, Alida (CDC/ONDIEH/NCIPC)
Sent: 26 Feb 2018 13:10:03 -0500
To: Black, Erin (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: CDC / SAMHSA SMVF TA Center Call

Yes, I had a call with Angela Wright and their graphic designer on February 8. They wanted art from the Technical Package poster showing the strategies. I sent them the design files for that illustration and the designer follow up that she had received the files and had everything she needed.
I also talked with them about sending hard copies of the TP for the event in March. I explained that a reprint is in process but we may not have 200 copies delivered from the printer in time for the event. I do have the last 50 copies squirreled away in my office, so if we don't have the reprint delivered I will send them the last 50 copies we have, and they will offer instructions about how to order a hard copy when our supply is restocked.
Thanks,
Alida

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Monday, February 26, 2018 12:47 PM
To: Knuth, Alida (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: CDC / SAMHSA SMVF TA Center Call

Deb – I haven't heard anything. Aldia did they ever contact you about this?

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, February 26, 2018 12:05 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: FW: CDC / SAMHSA SMVF TA Center Call

Hi Erin,
Have you heard any more about this? There has been little follow-up from the SMVF TA Center since the call which was a while ago now.
Deb

From: Angela Wright [mailto:awright@prainc.com]
Sent: Friday, February 02, 2018 3:51 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Donna Aligata <daligata@prainc.com>; Burrows-McElwain, Cicely (SAMHSA) <Cicely.Burrows-McElwain@samhsa.hhs.gov>; McKeon, Richard (SAMHSA/CMHS) <Richard.McKeon@samhsa.hhs.gov>; Philip Paty <ppaty@prainc.com>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Knuth, Alida (CDC/ONDIEH/NCIPC) <zlq5@cdc.gov>; Girod, Candace (CDC/ONDIEH/NCIPC) <mrv7@cdc.gov>
Subject: RE: CDC / SAMHSA SMVF TA Center Call

Thank you, Deb! I greatly appreciate the links and connecting me to Alida.
Alida, I'd like to set up a time to talk next week about the graphics and printing. I'll ask our project assistant to send you some available times under separate cover.
Have a wonderful weekend everyone!
Angela

From: Stone, Deborah (CDC/ONDIEH/NCIPC) [mailto:zaf9@cdc.gov]
Sent: Friday, February 02, 2018 3:17 PM
To: Angela Wright <awright@prainc.com>; Donna Aligata <daligata@prainc.com>; Burrows-McElwain, Cicely (SAMHSA) <Cicely.Burrows-McElwain@samhsa.hhs.gov>; McKeon, Richard (SAMHSA/CMHS) <Richard.McKeon@samhsa.hhs.gov>; Philip Paty <ppaty@prainc.com>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Knuth, Alida (CDC/ONDIEH/NCIPC)

<zlq5@cdc.gov>; Girod, Candace (CDC/ONDIEH/NCIPC) <mrv7@cdc.gov>
Subject: RE: CDC / SAMHSA SMVF TA Center Call

Thank you so much, Angela and the rest of the team. It was so great to talk to you today and I very much appreciate you sending along the materials. What a wonderful opportunity you are providing to cities! Here's the link to access the suicide technical package (https://wwwn.cdc.gov/pubs/CDCInfoOnDemand.aspx?ProgramID=62) . When you click on the link, if it doesn't take you directly to the technical package page, enter Violence Prevention: Suicide in the first drop down list. *However,* the document is currently out of stock (but save the link for future reference!). I'm cc'ing Alida Knuth who can provide guidance on how best to get the number of copies you need. Alida can also provide guidance around the use of the graphics you are interested in reproducing from the technical package and from the infographic.

I look forward to continued conversations!

Have a great weekend!

Deb

Deb Stone, ScD, MSW, MPH
Behavioral Scientist
Suicide, Youth Violence, and Elder Maltreatment Team
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Research & Evaluation Branch
4770 Buford Highway, MS F-64
Atlanta, GA 30341
770.488.3942
dstone3@cdc.gov

From: Angela Wright [mailto:awright@prainc.com]
Sent: Friday, February 2, 2018 11:39 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Girod, Candace (CDC/ONDIEH/NCIPC) <mrv7@cdc.gov>; Donna Aligata <daligata@prainc.com>; Burrows-McElwain, Cicely (SAMHSA) <Cicely.Burrows-McElwain@samhsa.hhs.gov>; McKeon, Richard (SAMHSA/CMHS) <Richard.McKeon@samhsa.hhs.gov>; Philip Paty <ppaty@prainc.com>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: CDC / SAMHSA SMVF TA Center Call

Good morning,

Thank you for a great call today. We are so pleased to be able to collaborate and help roll out the CDC Suicide Prevention Technical Package to cities this year. As promised on the call, I am attaching the following items:

- Save-the-Date
- Mayor's Challenge Fact Sheet
- Team Selection Tool
- Contact sheet for the Mayor's Challenge
- Article on the Implementation Academy model

Please let me know how I can get in touch with Alita Knuth, so I may work with her on obtaining graphics and copies of the Technical Package as handouts for the Academy on March 14-16. We also look forward to being connected with those who are working on the implementation guidance.

Again, we appreciate your time today. Let us know if you have any questions as you read through the materials we've provided.

Warm regards,

Angela J. Wright, J.D.
Assistant Director

SAMHSA's Service Members, Veterans, and
Their Families Technical Assistance Center
Policy Research Associates, Inc.
345 Delaware Ave.
Delmar NY, 12054
Phone: 518.439.7415 ext. 5258
Fax: 860.295.6481
Email: awright@prainc.com
http://www.samhsa.gov/smvf-ta-center
www.prainc.com
Creating positive social change for people who are disadvantaged through technical assistance, research, and training.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 17 Apr 2018 02:06:11 +0000
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC);Sokler, Lynn (CDC/OD/OADC);Peaker, Brandy (CDC/OPHSS/CSELS/DPHID);Omisore, Shannon L. (CDC/OD/OADC)
Subject: RE: Change in June VS release date go Thurs June 7

Thank you for the update Rich. Sharing with our team now.
Deb

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Monday, April 16, 2018 6:35 PM
To: Schuchat, Anne MD (CDC/OD) ; Daniel, Katherine Lyon (CDC/OD/OADC) ; Dauphin, Leslie (CDC/OD/OADLSS)
Cc: Sorrells, Marjorie J. (CDC/OD/OCS) ; Downie, Diane (Dee Dee) (CDC/CGH/DGHP) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Sokler, Lynn (CDC/OD/OADC) ; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) ; Omisore, Shannon L. (CDC/OD/OADC) ; Harben, Kathy (CDC/OD/OADC) ; Bonds, Michelle E. (CDC/OD/OADC) ; Roberts, Ursula (CDC/OD/OCS) (CTR) ; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) ; Glynn, Kate (CDC/OPHSS/CSELS/DSEPD) ; Iademarco, Michael (CDC/OPHSS/CSELS/OD) ; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) ; Smith, Rhonda K. (CDC/OD/OADC) ; Smith, Patti (CDC/OD/OADC) ; Guest, Megan (CDC/OD/OADC)
Subject: Change in June VS release date go Thurs June 7

Folks,
We're now set up have the Tues June 5 Suicide Prevention VS release and telebriefing moved to Thurs June 7 at Noon instead. There will not be an early release of this issue as we usually do. This should better accomodate Dr. Schuchat's travel schedule.
Thank you.
Rich

Rich Schieber, MD MPH
CAPT, USPHS
Director, CDC Vital Signs Program
RBS4@cdc.gov
404 697 9666

From: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Sent: 30 May 2018 18:40:11 -0400
To: Schuchat, Anne MD (CDC/OD)
Cc: Sokler, Lynn (CDC/OD/OADC);Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Subject: Re: change to Vital Signs telebriefing lineup- need your input

Got it. Sounds good!

From: Schuchat, Anne MD (CDC/OD)
Date: May 30, 2018 at 6:27:43 PM EDT
To: Houry, Debra E. (CDC/ONDIEH/NCIPC)
Cc: Dorigo, Leslie (CDC/ONDIEH/NCIPC) , Sokler, Lynn (CDC/OD/OADC)
Subject: Re: change to Vital Signs telebriefing lineup- need your input

Suggest solid but offer Sg options to tweet or do other messaging on his own schedule and give his office slides nd TPs to use prn

Sent from my iPhone

On May 30, 2018, at 5:18 PM, Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov> wrote:

> Hi Anne
> My comm director called me today after talking to Vital Signs office (both cc'd) and wanted to get your thoughts on some options for the Vital Signs telebriefing. SG can no longer do the date/time of the telebriefing. He's offered to do a pre-recorded message for telebriefing, however this hasn't been done before to my knowledge and doesn't really seem like the right flow or time to do that. Potential options include:
>
> - We could ask for the SG to release a brief, written media statement supportive of the VS
> - SG office also suggested we have the ASH do the telebriefing (as a short call-topper)- caveat being I don't know if he's available. He's also given feedback at various points and has a focus area more aligned with serious mental illness vs our 'more than mental health message'. But, on the flip side he's been very interested and supportive of CDC work and this might be a way to get our suicide prevention work and NVDRS more on his radar.
> - Or, you could do telebriefing solo
>
> Thoughts? Happy to chat more offline through these options too
> Deb

From: /o=cdc/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=f43dd520d1854120aa942ac284dc7713-discoverysearchmailb
Sent: 13 Feb 2018 18:07:32 +0000
Subject: RE: Clarification of meeting dates and details

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, February 12, 2018 12:49 PM
To: Sokler, Lynn (CDC/OD/OADC)
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) ; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) ; Omisore, Shannon L. (CDC/OD/OADC)
Subject: Clarification of meeting dates and details

Hi Lynn,
It was nice to meet you last week at the kick-off meeting. I was reviewing the calendar and the list of meetings (from the CDC Vital Signs Products document) side by side and I had some questions. Would you be able to check the info I have and fill in any of the blanks? I just want to make sure everything gets on the calendar accurately and with plenty of notice. Also, if you could let me know what the colors on the calendar mean again that would be helpful. I know the green are items with the same date and it looks like pink indicates program deliverables (but not all). Thank you!
Deb

Meeting	Date	Time	Location	Corresponding step from calendar	Note
~~1. Initial Kick-off~~	~~February 8, 2018~~	~~9-10:30~~	~~Chamblee~~	———	**completed**
2. Roundtable	**April 3**	**1:30-4:30**	**Chamblee**	**13**	**SMEs, Comm, Policy go word for word Need AV equipment**
3. Medical Outreach Call	**Week of 4/11-4/15**			**23**	**30 min call, send invite Main comms and partnership people**
4. Town Hall Prep	**Around May 8th**			**24**	**Tanya Joiner main contact, can contact her to set up**
5. Social Media kickoff prep call	**April 24**			**35/36 (4 and 6 weeks ahead)**	**OADC, Shannon will**

					schedule; email her; will be a call
6. Pre-briefing meetings with Director/AS/ADS	May 7th week		Bldg 21, 12th fl	40	We'll get that on the calendar in March/ 45 min to go over main messages. Dr S gets in the weeds. Discuss tough questions from the media.
7. Media Telebriefing and pre-release meeting	June 5	11:40-12 pre meeting with Dr. S Telebriefing Noon with media Release 12-12:30	Bldg 21, 12th fl	48	Dr. S will send invites
8. OSTLTS Town Hall	June 12	Maybe at 2 pm		51	Tanya joiner will go over details.

I send:
Medical outreach—send invite to brandy (call-30 min)
Roundtable confirmation (rich, brandy, lynn, Shannon)
Podcast is optional
NPHIC call Thursday before release, contact Shannon about this.
Shannon 3 meetings in total
Everything in the fact sheet has to be in the mmwr
Science clips—give list of 10 references (bibliography); 8 have to be from MMWR; 2 from review articles for reader context (meta-analysis, systematic review, IOM report), summary of topic area (highlight these)
Abstract
Median, quartiles instead of alphabetically.
MMWR/Factsheet word version (non cleared)—these are used at the roundtable
Revise factsheets after R/T
MMWR and Factsheet sent to OD for first review (cleared)
OD will review and give comments
Respond to comments on factsheet and mmwr

Revisions to MMWR go to Scholar One to MMWR Editors (normal process—VS team hands off)
Another revised version of the fact sheet and that goes back to VS (we go back and forth on that with graphics)
Ideas for graphics from us, maps will be different; whole integers, collapse categories (could be increase, decrease, stay the same)
Graphic version of the FS to OD along with all other pre-brief materials (mmwr, telebriefing script, Q&A, press release, dear colleague letter)
We have another chance for revisions after this
Graphic FS and press release goes to ASPAA HHS for clearance (only thing) –Step 20 they have a week to review
Revise again (hopefully no substantive comments which would
FS lockdown a week before release
Discussion section—there are roles for multiple partners in addressing this problem which include (insert high level items)
All data in the FS has to be in MMWR

Deb Stone, ScD, MSW, MPH
Behavioral Scientist
Suicide, Youth Violence, and Elder Maltreatment Team
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Research & Evaluation Branch
4770 Buford Highway, MS F-64
Atlanta, GA 30341
770.488.3942
dstone3@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 12 Feb 2018 21:27:48 +0000
To: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Subject: RE: Clarification of meeting dates and details

Hi Brandy,
I was in a training all afternoon but thanks so much for the reply. I'm sending you an invite now for tomorrow.
Deb

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: Monday, February 12, 2018 4:01 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Clarification of meeting dates and details

Deb – doesn't look like we will be able to connect today. I'm open all day tomm, but then out of the office the rest of the week. Are you available anytime tomm? I develop the calendars so am the best person on the team to answer questions about it.

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: Monday, February 12, 2018 1:00 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: Re: Clarification of meeting dates and details

Hi Deb - I can help with explaining calendar dates. Are you available this afternoon to chat. Maybe 3:00?
Thanks,
Brandy

From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Date: February 12, 2018 at 12:48:52 PM EST
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>, Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>, Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: Clarification of meeting dates and details

Hi Lynn,
It was nice to meet you last week at the kick-off meeting. I was reviewing the calendar and the list of meetings (from the CDC Vital Signs Products document) side by side and I had some questions. Would you be able to check the info I have and fill in any of the blanks? I just want to make sure everything gets on the calendar accurately and with plenty of notice. Also, if you could let me know what the colors on the calendar mean again that would be helpful. I know the green are items with the same date and it looks like pink indicates program deliverables (but not all). Thank you!
Deb

Meeting	Date	Time	Location	Corresponding step from	Note

				calendar	
~~1. Initial Kick-off~~	~~**Februar y 8, 2018**~~	~~**9-10:30**~~	~~**Chamblee**~~	~~_____~~	**completed**
2. Roundtable	**April 3**	**1:30-4:30**		**13**	
3. Social Media kickoff prep call	**April 24**			**35**	
4. Recording of podcast (by phone or in person)					**Don't see this on calendar**
5. NPHIC Call	**May 31**			**42**	
6. Pre-briefing meetings with Director/AS			**Bldg 21, 12th fl**	**41**	
7. Media Telebriefing and pre-release meeting	**June 5**	**11:40**	**Bldg 21, 12th fl**	**48**	
8. OSTLTS Town Hall	**June 12**			**51**	

Deb Stone, ScD, MSW, MPH
Behavioral Scientist
Suicide, Youth Violence, and Elder Maltreatment Team
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National Center for Injury Prevention and Control
Division of Violence Prevention
Research & Evaluation Branch
4770 Buford Highway, MS F-64
Atlanta, GA 30341
770.488.3942
dstone3@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 8 Jun 2018 14:20:40 +0000
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Subject: RE: Congratulations everyone!!

Thanks, Linda!

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 10:18 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC)
Cc: Mercy, James (CDC/ONDIEH/NCIPC) ; Young, Joni (CDC/ONDIEH/NCIPC) ; Basile, Kathleen (CDC/ONDIEH/NCIPC) ; Ferdon, Corinne (CDC/ONDIEH/NCIPC) ; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) ; Massetti, Greta M. (CDC/ONDIEH/NCIPC) ; Payne, Gayle H. (CDC/ONDIEH/NCIPC) ; Ballesteros, Michael (Mick) (CDC/ONDIEH/NCIPC) ; Kresnow-Sedacca, Marcie-jo (CDC/ONDIEH/NCIPC)
Subject: Congratulations everyone!!

Awesome team! Awesome work! Congratulations on the Vital Signs. I couldn't be more proud of you and all that you have done to elevate this issue and provide compelling and actionable information for the nation to prevent suicide.

I watched the news last night and have been listening to the news this morning covering Anthony Bourdain's death. The news stations are going into greater detail about the findings from the Vital Signs and telling viewers that we need to do more to stay connected to those around us and to be aware of how relationship and financial problems and other things going on in people's lives contribute to suicide. The findings and the prevention messages are getting out there.

Well done everyone!

Linda

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 3:43 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Young, Joni (CDC/ONDIEH/NCIPC) <gzc8@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Cc: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Basile, Kathleen (CDC/ONDIEH/NCIPC) <ksb9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC) <kzm2@cdc.gov>; Payne, Gayle H. (CDC/ONDIEH/NCIPC) <hfn5@cdc.gov>; Massetti, Greta M. (CDC/ONDIEH/NCIPC) <ghz6@cdc.gov>
Subject: VS release

Hi everyone,

The Vital Signs launch went really well! Dr. Shuchat and Deb did a great job on the telebriefing! You would have thought that Dr. Shuchat had been involved in writing the report by the way that she handled the questions.

I wanted to let you know that many stories are already published. I'm sure we'll have a summary later but I encourage you to do a Google news search on "CDC" and "suicide" and you can get a sense. It is great to see how often the reports talk about the need to broaden suicide prevention efforts, and they frequently include a link to the technical package and the Lifeline. Here is a partial sweep that Crystal shared.

http://time.com/5304468/suicide-rates-by-state/
https://www.upi.com/Health_News/2018/06/07/CDC-Suicide-rates-rose-30-across-nation-since-1999/4231528377010/
https://www.bloomberg.com/news/articles/2018-06-07/amid-drastic-rise-in-suicide-cdc-says-it-s-not-just-about-mental-health
https://www.npr.org/sections/health-shots/2018/06/07/617897261/cdc-u-s-suicide-rates-have-climbed-dramatically
http://thehill.com/policy/healthcare/391170-cdc-suicide-rates-increasing-in-almost-every-state
https://www.cnn.com/2018/06/07/health/suicide-report-cdc/index.html
https://www.nbcnews.com/health/health-news/suicide-rates-are-30-percent-1999-cdc-says-n880926
https://www.cbsnews.com/news/suicide-rates-rise-more-than-a-mental-health-issue-cdc-says/
https://www.indystar.com/story/news/2018/06/07/cdc-suicide-now-10th-leading-cause-death-cause-rise/681605002/
http://www.nydailynews.com/news/national/ny-news-us-suicide-rates-rising-20180607-story.html
https://abcnews.go.com/Politics/cdc-report-finds-rise-suicide-rates-states/story?id=55719214
Also, check out this Joint Statement from the Action Alliance supporting our findings:
http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Action%20Alliance_A%20Joint%20Statement_CDC%20Vital%20Signs%20June.pdf
Thanks go to Erin, Molly, Alex, and Kristin for representing us on the call with the Action Alliance that led to this!
It is very encouraging. More to come.
-Tom

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: 25 Apr 2018 23:38:28 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC);Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Subject: RE: Correction RE: **VS Updates**

I'm sorry to hear about the commentary, Deb. Still, it looks like everything else is going very well, and it sounds like one of these items (pics for the FS) was checked off today! You're doing a great job keeping the ball rolling!
Kristin

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 25, 2018 9:21 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD)
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) ; Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Subject: Correction RE: **VS Updates**
Importance: High

Pre-brief is on **May 8th** not May 7th! My apologies. Thank you, Alex and thank you, Malia for the additional updates, terrific!
Deb

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 25, 2018 12:15 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>
Subject: **VS Updates**

Hi Everyone,
Since we didn't have a meeting last week or this week (yikes!) and our next meeting isn't until next Tuesday, I wanted to take the time to provide some updates to keep everyone in the loop (apologies for the delay on this). I invite anyone to add to this update in case I've forgotten anything, which I'm so sure I have.

One REQUEST: By next week it would be great if the three task groups (MMWR, Fact Sheet, Comm/Policy) can update their to-do lists through May 15th. I don't have any specific guidance since it's late but will be good to keep ourselves organized and no what's coming next (mostly I'm suggesting this for myself probably!).

Where things stand currently:

- The **MMWR** was routed through clearance and cross-clearance successfully. It will be submitted to the MMWR office today.
- The **Fact sheet** team led heroically by Tom and aided by Crystal, Kristin, Asha, and myself has come a long way! Thank you to everyone who reviewed the latest version of the FS. Tom will submit the FS back to the VS team COB.
    - One sticking point right now is finding two good photos to include! This is no small task. The first photo is on page 1 and is next to the 'states and communities can: [insert 7 strategies]. Here some are thinking a group of people would be good to suggest organizing, collaboration, and connectedness. However, it really needs to convey the problem of suicide somehow. The second picture is placed right next to the heading on page 2 about the percentage change in rate increases. This is not a happy message of course so what do we place there? Trying to avoid depressed looking people. I personally am also trying to avoid pictures of women and teenagers so we represent the population with the highest burden, men. Molly and Crystal are helping with this conundrum. Attaching latest mock-up of FS.
    - Also, Molly now has the native files of the Bethe1to campaign image in her hands (yay!). Please see attached for what I'm talking about. The folks at Mental Health America are thrilled that their campaign will be featured.
- The **Comm team** has been extremely busy drafting the critical contacts email, the telebriefing script, the press release, and the dear colleague letter. These documents were routed from Crystal to Marie, myself, Malia, Tom, and will be reviewed in the next day by Leslie. These items are due to the VS office this Friday, April 27th. I'm working on some FAQs today to include with the telebriefing script.
- Re **Partnerships**, Dr. Schuchat mentioned the VS at the Action Alliance Executive Committee meeting a few weeks ago, and Robin Ikeda mentioned the VS at the American Association of Suicidology meeting last week. Kristin also mentioned the VS to the Data and Surveillance Task Force of the Action Alliance, and she and I met with Colleen Carr and Farrah Kaufmann also of the Action Alliance. Kimberly Torguson of the Action Alliance's Media workgroup has been alerted as have Federal Partners on our monthly call. **It was recommended that we reach out to the National Council for Suicide Prevention if we haven't already done so. An update re the Surgeon General's participation is forthcoming (Feel free to update here).
- The medical outreach call with Brandy Peaker occurred this past Monday. This was a productive meeting. **Feel free to update here.
- The **pre-briefing** with Dr. Schuchat has been scheduled and rescheduled multiple times. It's currently on May 8th from 1-1:45. In addition, to accommodate Dr. Schuchat's travel schedule the VS has been pushed back until **JUNE 7th**.
- **NCHS data brief** on suicide will be delayed until after our VS comes out. That was very generous of them. Thanks to Tom for working that out!
- One piece of bad news, the **AJPH commentary** was rejected ☹ I will assess whether it makes sense to try JAMA or AJPM (i.e. whether content is appropriate and whether timing is at all possible—guessing no on both fronts). The next idea is to have a commentary come out after the VS in another journal.

- Other items—I'm sure I'm forgetting or don't know about many things so please add here!

That's all for now. Sorry for the overly long email. Please let me know if you have any questions or concerns. Thanks a million to everyone for the great work. We've really made great strides thus far! Six week to go. Go Team! ☺

Deb

Deb Stone, ScD, MSW, MPH
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National Center for Injury Prevention and Control
Division of Violence Prevention
Suicide, Youth Violence & Elder Maltreatment Team
770.488.3942
dstone3@cdc.gov

CDC's Injury Center
Preventing Injuries and Violence Through Science and Action

From: Basile, Kathleen (CDC/ONDIEH/NCIPC)
Sent: 14 Jun 2018 12:38:45 -0400
To: Holland, Kristin (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: cost of suicide source

Actually, I just found in the Vital signs that you cited WISQARS. Thanks and sorry to bother you!
K

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 14, 2018 12:38 PM
To: Basile, Kathleen (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: cost of suicide source

Hi Kathleen,
I think that's a conservative estimate. Another study we reference in the TP suggests the costs were about $93.5 billion in 2013 after adjusting for under reporting of suicide, and drawing on health expenditures per capita, GDP per capita, and varability among states in per capita health expenditures and income. Reference: Shepard DS, Gurewich D, Lwin AK, Reed GA, Jr., Silverman MM. Suicide and suicidal attempts in the United States: costs and policy implications. *Suicide Life Threat Behav.* 2016;46(3):352-362.
Kristin

From: Basile, Kathleen (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 14, 2018 12:32 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: cost of suicide source

Hi Deb and Kristin, I am working on the self-harm objective proposal for Healthy People 2030, and I'm trying to find info about the economic cost of suicide. I see on our website that we say Suicide and suicide attempts cost society about **$70 billion** a year in combined medical and work loss costs. What is the source for that statement? There is no citation. I found the Corso, Mercy, Simon et al article but that appears to be the cost of interpersonal AND self-directed violence.
Thanks for any help, K

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 19 Jan 2018 20:01:28 +0000
To: Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: Discussion on NREPP and building the suicide prevention field

Exactly. It would be so easy for him to do. Sigh…

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, January 19, 2018 2:56 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Discussion on NREPP and building the suicide prevention field

Ya – I sensed Richard was lukewarm too – I was going to straight up ask him to include the technical package in their communication about the NREPP discontinuation as where people could now go for evidenced based suicide prevention approaches but thought not given the temperature….

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, January 19, 2018 2:51 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: Discussion on NREPP and building the suicide prevention field

Thanks for the notes Erin. I think we have more work to do with SAMHSA around promotion of the technical package. Jane has always been very positive about it. Richard is more lukewarm.
And yes, I think it would be good to make sure it's brought up at the Action Alliance meeting. And I will send a link to the listserv.
I'll keep you posted on other opportunities or anything I hear. Sorry the call wasn't more directly relevant. I thought there would be a greater focus on the technical package but I guess we're not all on the same page yet as to how the tp could help fill the gap.
Deb

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, January 19, 2018 2:44 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: Discussion on NREPP and building the suicide prevention field

Thanks Deb for letting me join the call and thanks for sending the matrix out. Sounds like you will send out the suicide technical package to the AAS list serve. I will make sure it's on Jim's radar to think about how we can help shape the conversation on where to find evidence based programs and policies now (i.e. the Technical Package) at the Action Alliance meeting. Let me know if you hear of other opportunities to ensure CDC and the technical package are part of the conversation.

-----Original Appointment-----
From: Kurikeshu, Rebecca (NIH/NIMH) [C]
Sent: Tuesday, January 16, 2018 11:48 AM
To: Kurikeshu, Rebecca (NIH/NIMH) [C]; McKeon, Richard (SAMHSA/CMHS); Reider, Eve (NIH/NIMH) [E]; Stone, Deborah (CDC/ONDIEH/NCIPC); Black, Erin (CDC/ONDIEH/NCIPC); Pearson, Jane L (NIH/NIMH) [E]
Subject: Discussion on NREPP and building the suicide prevention field
When: Friday, January 19, 2018 2:00 PM-3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: 866-808-4568 code 715 2974 #

Hello all, just a reminder that this conference call is today at 2pm.
866-808-4568
code (b)(6)
Talk to you soon.
Thanks,
Becky

From: Colleen Creighton
Sent: 11 Jun 2018 12:37:10 +0000
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Re: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Thanks so much for the clarification!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, June 11, 2018 8:36 AM
To: Colleen Creighton
Subject: FW: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Colleen,

I was provided update information; ethanol would not be included under other substances. My apologies.

Deb

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Sunday, June 10, 2018 11:26 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Thanks for following up Deb!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 3:29 PM
To: ccreighton@suicidology.org
Cc: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: FW: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Colleen,

I'm responding to your question that Erin shared.

The common substance under 'Other' are something like Acetaminophen, Diphenhydramine, eth. Also, it includes alcohol and ethanol.

We don't have specific substance class for those substance, so they are all under 'Other'.

I hope this helps!

Thanks,

Deb

Deb Stone, ScD, MSW, MPH
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

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770.488.3942
dstone3@cdc.gov

CDC's Injury Center

Preventing Injuries and Violence Through Science and Action

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 10:15 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: FW: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

See question below re the VS.

From: Colleen Creighton <ccreighton@suicidology.org>
Sent: Thursday, June 7, 2018 5:45 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin – Thanks so much for the call today and for all your work going into this report. One question that came up from our end is under "Other" – what is included in this category in addition to OTCS?

Other (e.g., over-the-counter)	**1,021 (34.0**

Thanks so much,

Colleen

Colleen Creighton
Executive Director
American Association of Suicidology
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T: (202) 237-2280, F: (202) 237-2282
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Register for FREE trainings here:
www.USMilitaryMatters.org
www.suicidology.org

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide.
AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research,
education and training, the development of standards and resources, and survivor support services.

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 10:04 AM
To: Torguson, Kimberly <KTorguson@edc.org>; Belyeu, Avery <ABelyeu@edc.org>; jbenson@reingold.com; Bray, Miranda (SAMHSA/OC) <Miranda.Bray@samhsa.hhs.gov>; Sam.Brinton@thetrevorproject.org; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Carr, Colleen <ccarr@edc.org>; SCoggin@afsp.org; Colleen Creighton <ccreighton@suicidology.org>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Curtin, Sally C. (CDC/OPHSS/NCHS) <sac2@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Ashby.Dodge@thetrevorproject.org; mgdyak@eiconline.org; johnd@mhaofnyc.org; fgonzalez@mhaofnyc.org; Gass, Jesse <JGass@edc.org>; Hausman, Bridgette <BHausman@edc.org>; Hedegaard, Holly (CDC/OPHSS/NCHS) <hdh6@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Amy Kulp <ajkulp@suicidology.org>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; wendy.e.lakso.civ@mail.mil; plauricella@reingold.com; sheri.lunn@thetrevorproject.org; Chris Maxwell <cmaxwell@suicidology.org>; McElroy, James (NIH/NIMH) [E] <james.mcelroy@nih.gov>; McShane, Kristen (SAMHSA/OC) <Kristen.Mcshane@samhsa.hhs.gov>; steve.mendelsohn@thetrevorproject.org; eneely@reingold.com; AOBrien@afsp.org; O'Keefe, Lindsey (NIH/NIMH) [E] ; Amit.Paley@thetrevorproject.org; jpearson@nih.gov; Pearson, Jane L (NIH/NIMH) [E] <jpearson@mail.nih.gov>; Reed, Jerry <jreed@edc.org>; dreidenberg@save.org; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; mrosen@mhaofnyc.org; michaelle.scanlon@nih.gov; Sobottka, Linda <lsobottka@edc.org>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Stout, Elly <estout@edc.org>; calvin.stowell@thetrevorproject.org; AVactor@mhaofnyc.org; Warner, Margaret (CDC/OPHSS/NCHS) <mmw9@cdc.gov>; katherine.v.warrick.civ@mail.mil; kevin.wong@thetrevorproject.org; Wright, James (SAMHSA/DPTSSP) <James.Wright@samhsa.hhs.gov>
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

In prep for our call today to discuss our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* attached is an **embargoed** copy of the Fact Sheet. The Vital Signs includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions. We appreciate this partnership and hope you can all help us disseminate the Vital Signs to your networks once the **embargo lifts at 1:00 pm**.

Erin

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The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains an advance copy of the four-page *Vital Signs* fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; the attachment is EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

-----Original Appointment-----

From: Torguson, Kimberly <KTorguson@edc.org>

Sent: Monday, May 14, 2018 6:59 PM

To: Torguson, Kimberly; Belyeu, Avery; jbenson@reingold.com; Black, Erin (CDC/ONDIEH/NCIPC); Bray, Miranda (SAMHSA/OC); Sam.Brinton@thetrevorproject.org; Bruce, Crystal (CDC/OPHPR/OD); Carr, Colleen; SCoggin@afsp.org; ccreighton@suicidology.org; Crosby, Alexander (CDC/ONDIEH/NCIPC); Curtin, Sally C. (CDC/OPHSS/NCHS); Daniel, Valerie M. (CDC/ONDIEH/NCIPC); Ashby.Dodge@thetrevorproject.org; mgdyak@eiconline.org; JohnD@mhaofnyc.org; fgonzalez@mhaofnyc.org; Gass, Jesse; Hausman, Bridgette; Hedegaard, Holly (CDC/OPHSS/NCHS); Holland, Kristin (CDC/ONDIEH/NCIPC); ajkulp@suicidology.org; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC); wendy.e.lakso.civ@mail.mil; plauricella@reingold.com; sheri.lunn@thetrevorproject.org; cmaxwell@suicidology.org; McElroy, James (NIH/NIMH) [E]; McShane, Kristen (SAMHSA/OC);

steve.mendelsohn@thetrevorproject.org; eneely@reingold.com; AOBrien@afsp.org; O'Keefe, Lindsey (NIH/NIMH) [E]; Amit.Paley@thetrevorproject.org; jpearson@nih.gov; Pearson, Jane L (NIH/NIMH) [E]; Reed, Jerry; dreidenberg@save.org; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); mrosen@mhaofnyc.org; michaelle.scanlon@nih.gov; Sobottka, Linda; Stone, Deborah (CDC/ONDIEH/NCIPC); Stout, Elly; calvin.stowell@thetrevorproject.org; AVactor@mhaofnyc.org; Warner, Margaret (CDC/OPHSS/NCHS); katherine.v.warrick.civ@mail.mil; kevin.wong@thetrevorproject.org; Wright, James (SAMHSA/DPTSSP)
Subject: Media Messaging Work Group Call
When: Thursday, June 7, 2018 11:00 AM-11:30 AM (UTC-05:00) Eastern Time (US & Canada).
Where: Phone Number: 866-370-2808 (access code (b)(6)
Phone Number: 866-370-2808 (access code (b)(6)
Email Context (From 5/14):
Hello Media Messaging Work Group (MMWG),
Following the email below, we wanted to let you know that the CDC data expected to be released on June 5 will **now be released on June 7**. Additionally, we received word that we will not be receiving an embargoed copy so we'll be rescheduling our MMWG group call (originally scheduled for Thursday, May 31) to **Thursday, June 7 at 11:00 a.m.**

The goal of this call is to convene our partners to: 1) discuss the data, and 2) develop consensus on our messaging that will be used to craft a statement. If you are unable to join the call, you will still have the opportunity to weigh in on the statement via email. We hope you can join us on Thursday, June 7 at 11:00 a.m.
Lastly, we want to thank CDC for giving us the heads up about the data.
Best,

Hello Media Messaging Work Group,
We wanted to call to your attention to a just-released article published in the *American Journal of Preventive Medicine* that looks at county-specific estimates of suicide rates. The paper titled "County-level Trends in Suicide Rates in the U.S., 2005-2015" was written by our Partner, CDC (authors include: Lauren M. Rossen, Holly Hedegaard, Diba Khan and Margaret Warner from NCHS).
Key findings include:

- Posterior predicted mean county-level suicide rates increased by >10% from 2005 to 2015 for 99% of counties in the U.S., with 87% of counties showing increases of >20%.
- Counties with the highest model-based suicide rates were consistently located across the western and northwestern U.S., with the exception of southern California and parts of Washington.
- Compared with more urban counties, more rural counties had the highest estimated suicide rates from 2005 to 2015, and also the largest increases over time.

Overall the data underscores the importance of looking at geographic areas to identify high risk and need for more coordinated and comprehensive community-based suicide prevention efforts in the U.S.

While the Action Alliance does notplan to put out a formal statement about the data at this time, we encourage you to reference our past collective statement (written in collaboration with the MMWG partners) released last year that looks at suicide rates in urban and rural areas. You'll notice much of the information is very relevant and timely as it relates to the county-level trends data.

Please find below some tailorable social media posts to help further promote the data:

- Data released by @CDCInjury featured in @AmJPrevMed shows county-level trends in suicide rates in the US http://bit.ly/2IHo6hk
- New article featured in @AmJPrevMed underscores need for coordinated and comprehensive community-based suicide prevention efforts http://bit.ly/2IHo6hk
    - Trends about suicide, like geographic patterns, helps us develop more targeted community-based #suicideprevention strategies http://bit.ly/2IHo6hk so we can reduce annual suicide rate 20% by 2025
    - Rural counties in the U.S. had the highest estimated suicide rates from 2005-2015 according to just-released @AmJPrevMed http://bit.ly/2IHo6hk
    - Tracking county-level suicide rates helps our field to better understand changes in suicide rates over time and develop more targeted suicide prevention efforts http://bit.ly/2IHo6hk
    - Together we can reduce the annual suicide rate 20 percent by 2025 but we need continued research on community-level risk and protective factors as shown in recent data by @CDCinjury http://bit.ly/2IHo6hk

When posting, please consider incorporating Media Messaging Work Group Partner Twitter handles:

- @Action_Alliance
- @AASuicidology
- @afspnational
- @CDCInjury
- @CDCMMWR
- @DeptofDefense
- @DeptVetAffairs
- @EDCTweets
- @NIH
- @NIMHgov
- @ReingoldInc
- @samhsagov
- @SAVEvoicesofedu
- @SPRCtweets
- @TrevorProject
- @800273TALK

Some resources that you may also find helpful as you promote the data include:

- **Action Alliance's *Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention*** – A resource that outlines

strategic components that should guide program planning and implementation at the community level.

- ***CDC's Preventing Suicide: A Technical Package of Policy, Programs, and Practices*** – A resourcethat helps states and communities prioritize efforts to prevent suicide.
  We wanted to give you all the heads up that CDC is also expected to release additional relevant data to inform suicide prevention efforts on or around June 5th. The Action Alliance Secretariat does plan to convene this group to develop consensus messaging around this impending data release. In preparation for this larger data release, we'll be convening the MMWG for a call in late May to discuss the data and our collective statement.
  REQUEST: Please join us for a planning call on Thursday, May 31 at 2:00 p.m. ET to plan ahead for collective statement about CDC data.
  We will send you a calendar invite (containing call-in information) to you shortly. If you are unable to participate on this call, you'll have the opportunity to weigh in on the statement electronically.
  Lastly, we wanted to thank CDC for giving us the heads up about the data.
  Thank you.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 11 Jun 2018 12:37:45 +0000
To: Yuan, Keming (CDC/ONDIEH/NCIPC)
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Thank you. I appreciate your attention to this!
Deb

From: Yuan, Keming (CDC/ONDIEH/NCIPC)
Sent: Monday, June 11, 2018 12:56 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Deb,
I run the code again during this weekend. The two most common substance under 'Other' are ACETAMINOPHEN and DIPHENHYDRAMINE. There is no Alcohol under 'Other' group.
Sorry for the confusion. Last Friday, I was in the class and run the code too quick to give it a careful thought. ☺
Thanks,
Keming

From: Yuan, Keming (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 4:23 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Deb,
Alcohol has its own class, which we didn't mean to include it in 'Other'.
In my coding, I only used substance class and didn't check substance name. In the data, some alcohol were put under 'Other' in error, which I didn't excluded. But, it didn't account for much.
Keming

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 3:22 PM
To: Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Thank you Keming!
Deb

From: Yuan, Keming (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 3:21 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Deb,
The common substance under 'Other' are something like Acetaminophen, Diphenhydramine, eth. Also, it includes Alcohol and ethanol.

We don't have specific substance class for those substance, so they are all under 'Other'.
Keming

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 1:10 PM
To: Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Thanks, Keming!
Deb

From: Yuan, Keming (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 1:09 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Deb,
I'm in training class now and I don't have access to SAS and my code. I will get it back to you later this afternoon.
Keming

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 10:32 AM
To: Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Subject: FW: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Can either of you help answer this questions?
Think it's things like Benadryl etc but not sure if there's a specific list or descriptor.
Deb

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 10:15 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: FW: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

See question below re the VS.

From: Colleen Creighton <ccreighton@suicidology.org>
Sent: Thursday, June 7, 2018 5:45 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin – Thanks so much for the call today and for all your work going into this report. One question that came up from our end is under "Other" – what is included in this category in addition to OTCS?

Other (e.g., over-the-counter)	**1,021 (34.0**

Thanks so much,

Colleen

Colleen Creighton
Executive Director
American Association of Suicidology
5221 Wisconsin Avenue, NW, 2nd Floor
Washington, DC 20015
T: (202) 237-2280, F: (202) 237-2282
Direct: 202-830-3399
Register for FREE trainings here:
www.USMilitaryMatters.org
www.suicidology.org



AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide.
AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 10:04 AM
To: Torguson, Kimberly <KTorguson@edc.org>; Belyeu, Avery <ABelyeu@edc.org>; jbenson@reingold.com; Bray, Miranda (SAMHSA/OC) <Miranda.Bray@samhsa.hhs.gov>; Sam.Brinton@thetrevorproject.org; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Carr, Colleen <ccarr@edc.org>; SCoggin@afsp.org; Colleen Creighton <ccreighton@suicidology.org>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Curtin, Sally C. (CDC/OPHSS/NCHS) <sac2@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Ashby.Dodge@thetrevorproject.org; mgdyak@eiconline.org; johnd@mhaofnyc.org; fgonzalez@mhaofnyc.org; Gass, Jesse <JGass@edc.org>; Hausman, Bridgette <BHausman@edc.org>; Hedegaard, Holly (CDC/OPHSS/NCHS) <hdh6@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Amy Kulp <ajkulp@suicidology.org>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; wendy.e.lakso.civ@mail.mil; plauricella@reingold.com; sheri.lunn@thetrevorproject.org; Chris Maxwell <cmaxwell@suicidology.org>; McElroy, James (NIH/NIMH) [E] <james.mcelroy@nih.gov>; McShane, Kristen (SAMHSA/OC) <Kristen.Mcshane@samhsa.hhs.gov>; steve.mendelsohn@thetrevorproject.org; eneely@reingold.com; AOBrien@afsp.org; O'Keefe, Lindsey (NIH/NIMH) [E] ; Amit.Paley@thetrevorproject.org; jpearson@nih.gov; Pearson, Jane L (NIH/NIMH) [E] <jpearson@mail.nih.gov>; Reed, Jerry <jreed@edc.org>; dreidenberg@save.org; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; mrosen@mhaofnyc.org; michaelle.scanlon@nih.gov; Sobottka, Linda <lsobottka@edc.org>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Stout, Elly <estout@edc.org>; calvin.stowell@thetrevorproject.org; AVactor@mhaofnyc.org; Warner, Margaret (CDC/OPHSS/NCHS) <mmw9@cdc.gov>; katherine.v.warrick.civ@mail.mil; kevin.wong@thetrevorproject.org; Wright, James (SAMHSA/DPTSSP)

<James.Wright@samhsa.hhs.gov>
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

In prep for our call today to discuss our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* attached is an **embargoed** copy of the Fact Sheet. The Vital Signs includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions. We appreciate this partnership and hope you can all help us disseminate the Vital Signs to your networks once the **embargo lifts at 1:00 pm**.

Erin

****

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains an advance copy of the four-page *Vital Signs* fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; the attachment is EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

-----Original Appointment-----

From: Torguson, Kimberly <KTorguson@edc.org>

Sent: Monday, May 14, 2018 6:59 PM

To: Torguson, Kimberly; Belyeu, Avery; jbenson@reingold.com; Black, Erin (CDC/ONDIEH/NCIPC); Bray, Miranda (SAMHSA/OC); Sam.Brinton@thetrevorproject.org; Bruce, Crystal (CDC/OPHPR/OD); Carr, Colleen; SCoggin@afsp.org; ccreighton@suicidology.org; Crosby, Alexander (CDC/ONDIEH/NCIPC); Curtin, Sally C. (CDC/OPHSS/NCHS); Daniel, Valerie M. (CDC/ONDIEH/NCIPC); Ashby.Dodge@thetrevorproject.org; mgdyak@eiconline.org; JohnD@mhaofnyc.org; fgonzalez@mhaofnyc.org; Gass, Jesse; Hausman, Bridgette; Hedegaard, Holly (CDC/OPHSS/NCHS);

Holland, Kristin (CDC/ONDIEH/NCIPC); ajkulp@suicidology.org; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC); wendy.e.lakso.civ@mail.mil; plauricella@reingold.com; sheri.lunn@thetrevorproject.org; cmaxwell@suicidology.org; McElroy, James (NIH/NIMH) [E]; McShane, Kristen (SAMHSA/OC); steve.mendelsohn@thetrevorproject.org; eneely@reingold.com; AOBrien@afsp.org; O'Keefe, Lindsey (NIH/NIMH) [E]; Amit.Paley@thetrevorproject.org; jpearson@nih.gov; Pearson, Jane L (NIH/NIMH) [E]; Reed, Jerry; dreidenberg@save.org; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); mrosen@mhaofnyc.org; michaelle.scanlon@nih.gov; Sobottka, Linda; Stone, Deborah (CDC/ONDIEH/NCIPC); Stout, Elly; calvin.stowell@thetrevorproject.org; AVactor@mhaofnyc.org; Warner, Margaret (CDC/OPHSS/NCHS); katherine.v.warrick.civ@mail.mil; kevin.wong@thetrevorproject.org; Wright, James (SAMHSA/DPTSSP)
Subject: Media Messaging Work Group Call
When: Thursday, June 7, 2018 11:00 AM-11:30 AM (UTC-05:00) Eastern Time (US & Canada).
Where: Phone Number: 866-370-2808 (access code (b)(6)
Phone Number: 866-370-2808 (access code (b)(6)
Email Context (From 5/14):
Hello Media Messaging Work Group (MMWG),
Following the email below, we wanted to let you know that the CDC data expected to be released on June 5 will **now be released on June 7**. Additionally, we received word that we will not be receiving an embargoed copy so we'll be rescheduling our MMWG group call (originally scheduled for Thursday, May 31) to **Thursday, June 7 at 11:00 a.m.**

The goal of this call is to convene our partners to: 1) discuss the data, and 2) develop consensus on our messaging that will be used to craft a statement. If you are unable to join the call, you will still have the opportunity to weigh in on the statement via email.
We hope you can join us on Thursday, June 7 at 11:00 a.m.
Lastly, we want to thank CDC for giving us the heads up about the data.
Best,

Hello Media Messaging Work Group,
We wanted to call to your attention to a just-released article published in the *American Journal of Preventive Medicine* that looks at county-specific estimates of suicide rates. The paper titled "County-level Trends in Suicide Rates in the U.S., 2005-2015" was written by our Partner, CDC (authors include: Lauren M. Rossen, Holly Hedegaard, Diba Khan and Margaret Warner from NCHS).
Key findings include:

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- Compared with more urban counties, more rural counties had the highest estimated suicide rates from 2005 to 2015, and also the largest increases over time.

Overall the data underscores the importance of looking at geographic areas to identify high risk and need for more coordinated and comprehensive community-based suicide prevention efforts in the U.S. While the Action Alliance does notplan to put out a formal statement about the data at this time, we encourage you to reference our past collective statement (written in collaboration with the MMWG partners) released last year that looks at suicide rates in urban and rural areas. You'll notice much of the information is very relevant and timely as it relates to the county-level trends data.
Please find below some tailorable social media posts to help further promote the data:

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- Trends about suicide, like geographic patterns, helps us develop more targeted community-based #suicideprevention strategies http://bit.ly/2IHo6hk so we can reduce annual suicide rate 20% by 2025
- Rural counties in the U.S. had the highest estimated suicide rates from 2005-2015 according to just-released @AmJPrevMed http://bit.ly/2IHo6hk
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- @SPRCtweets
- @TrevorProject
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We wanted to give you all the heads up that CDC is also expected to release additional relevant data to inform suicide prevention efforts on or around June 5th. The Action Alliance Secretariat does plan to convene this group to develop consensus messaging around this impending data release. In preparation for this larger data release, we'll be convening the MMWG for a call in late May to discuss the data and our collective statement.

REQUEST: Please join us for a planning call on Thursday, May 31 at 2:00 p.m. ET to plan ahead for collective statement about CDC data.

We will send you a calendar invite (containing call-in information) to you shortly. If you are unable to participate on this call, you'll have the opportunity to weigh in on the statement electronically.

Lastly, we wanted to thank CDC for giving us the heads up about the data.
Thank you.

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 8 Jun 2018 10:32:45 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

thanks

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 10:32 AM
To: Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

I passed the question to Shane.
Deb

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 10:15 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: FW: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

See question below re the VS.

From: Colleen Creighton <ccreighton@suicidology.org>
Sent: Thursday, June 7, 2018 5:45 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin – Thanks so much for the call today and for all your work going into this report. One question that came up from our end is under "Other" – what is included in this category in addition to OTCS?

Other (e.g., over-the-counter)	**1,021 (34.0**

Thanks so much,

Colleen

Colleen Creighton
Executive Director
American Association of Suicidology
5221 Wisconsin Avenue, NW, 2nd Floor
Washington, DC 20015
T: (202) 237-2280, F: (202) 237-2282
Direct: 202-830-3399
Register for FREE trainings here:
www.USMilitaryMatters.org
www.suicidology.org



AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide.
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Sent: Thursday, June 7, 2018 10:04 AM
To: Torguson, Kimberly <KTorguson@edc.org>; Belyeu, Avery <ABelyeu@edc.org>; jbenson@reingold.com; Bray, Miranda (SAMHSA/OC) <Miranda.Bray@samhsa.hhs.gov>; Sam.Brinton@thetrevorproject.org; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Carr, Colleen <ccarr@edc.org>; SCoggin@afsp.org; Colleen Creighton <ccreighton@suicidology.org>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Curtin, Sally C. (CDC/OPHSS/NCHS) <sac2@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Ashby.Dodge@thetrevorproject.org; mgdyak@eiconline.org; johnd@mhaofnyc.org; fgonzalez@mhaofnyc.org; Gass, Jesse <JGass@edc.org>; Hausman, Bridgette <BHausman@edc.org>; Hedegaard, Holly (CDC/OPHSS/NCHS) <hdh6@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Amy Kulp <ajkulp@suicidology.org>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; wendy.e.lakso.civ@mail.mil; plauricella@reingold.com; sheri.lunn@thetrevorproject.org; Chris Maxwell <cmaxwell@suicidology.org>; McElroy, James (NIH/NIMH) [E] <james.mcelroy@nih.gov>; McShane, Kristen (SAMHSA/OC) <Kristen.Mcshane@samhsa.hhs.gov>; steve.mendelsohn@thetrevorproject.org; eneely@reingold.com; AOBrien@afsp.org; O'Keefe, Lindsey (NIH/NIMH) [E] ; Amit.Paley@thetrevorproject.org; jpearson@nih.gov; Pearson, Jane L (NIH/NIMH) [E] <jpearson@mail.nih.gov>; Reed, Jerry <jreed@edc.org>; dreidenberg@save.org; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; mrosen@mhaofnyc.org; michaelle.scanlon@nih.gov; Sobottka, Linda <lsobottka@edc.org>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Stout, Elly <estout@edc.org>; calvin.stowell@thetrevorproject.org; AVactor@mhaofnyc.org; Warner, Margaret (CDC/OPHSS/NCHS) <mmw9@cdc.gov>; katherine.v.warrick.civ@mail.mil; kevin.wong@thetrevorproject.org; Wright, James (SAMHSA/DPTSSP) <James.Wright@samhsa.hhs.gov>
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

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After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).
Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.
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Sent: Monday, May 14, 2018 6:59 PM
To: Torguson, Kimberly; Belyeu, Avery; jbenson@reingold.com; Black, Erin (CDC/ONDIEH/NCIPC); Bray, Miranda (SAMHSA/OC); Sam.Brinton@thetrevorproject.org; Bruce, Crystal (CDC/OPHPR/OD); Carr, Colleen; SCoggin@afsp.org; ccreighton@suicidology.org; Crosby, Alexander (CDC/ONDIEH/NCIPC); Curtin, Sally C. (CDC/OPHSS/NCHS); Daniel, Valerie M. (CDC/ONDIEH/NCIPC); Ashby.Dodge@thetrevorproject.org; mgdyak@eiconline.org; JohnD@mhaofnyc.org; fgonzalez@mhaofnyc.org; Gass, Jesse; Hausman, Bridgette; Hedegaard, Holly (CDC/OPHSS/NCHS); Holland, Kristin (CDC/ONDIEH/NCIPC); ajkulp@suicidology.org; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC); wendy.e.lakso.civ@mail.mil; plauricella@reingold.com; sheri.lunn@thetrevorproject.org; cmaxwell@suicidology.org; McElroy, James (NIH/NIMH) [E]; McShane, Kristen (SAMHSA/OC); steve.mendelsohn@thetrevorproject.org; eneely@reingold.com; AOBrien@afsp.org; O'Keefe, Lindsey (NIH/NIMH) [E]; Amit.Paley@thetrevorproject.org; jpearson@nih.gov; Pearson, Jane L (NIH/NIMH) [E]; Reed, Jerry; dreidenberg@save.org; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); mrosen@mhaofnyc.org; michaelle.scanlon@nih.gov; Sobottka, Linda; Stone, Deborah (CDC/ONDIEH/NCIPC); Stout, Elly; calvin.stowell@thetrevorproject.org; AVactor@mhaofnyc.org; Warner, Margaret (CDC/OPHSS/NCHS); katherine.v.warrick.civ@mail.mil; kevin.wong@thetrevorproject.org; Wright, James (SAMHSA/DPTSSP)
Subject: Media Messaging Work Group Call
When: Thursday, June 7, 2018 11:00 AM-11:30 AM (UTC-05:00) Eastern Time (US & Canada).
Where: Phone Number: 866-370-2808 (access code (b)(6)
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The goal of this call is to convene our partners to: 1) discuss the data, and 2) develop consensus on our messaging that will be used to craft a statement. If you are unable to join the call, you will still have the opportunity to weigh in on the statement via email.
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Overall the data underscores the importance of looking at geographic areas to identify high risk and need for more coordinated and comprehensive community-based suicide prevention efforts in the U.S. While the Action Alliance does notplan to put out a formal statement about the data at this time, we encourage you to reference our past collective statement (written in collaboration with the MMWG partners) released last year that looks at suicide rates in urban and rural areas. You'll notice much of the information is very relevant and timely as it relates to the county-level trends data.
Please find below some tailorable social media posts to help further promote the data:

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- Trends about suicide, like geographic patterns, helps us develop more targeted community-based #suicideprevention strategies http://bit.ly/2IHo6hk so we can reduce annual suicide rate 20% by 2025
- Rural counties in the U.S. had the highest estimated suicide rates from 2005-2015 according to just-released @AmJPrevMed http://bit.ly/2IHo6hk
- Tracking county-level suicide rates helps our field to better understand changes in suicide rates over time and develop more targeted suicide prevention efforts http://bit.ly/2IHo6hk
- Together we can reduce the annual suicide rate 20 percent by 2025 but we need continued research on community-level risk and protective factors as shown in recent data by @CDCinjury http://bit.ly/2IHo6hk

When posting, please consider incorporating Media Messaging Work Group Partner Twitter handles:

- @Action_Alliance
- @AASuicidology
- @afspnational
- @CDCInjury
- @CDCMMWR
- @DeptofDefense
- @DeptVetAffairs
- @EDCTweets
- @NIH
- @NIMHgov
- @ReingoldInc
- @samhsagov
- @SAVEvoicesofedu
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- @TrevorProject
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REQUEST: Please join us for a planning call on Thursday, May 31 at 2:00 p.m. ET to plan ahead for collective statement about CDC data.

We will send you a calendar invite (containing call-in information) to you shortly. If you are unable to participate on this call, you'll have the opportunity to weigh in on the statement electronically.

Lastly, we wanted to thank CDC for giving us the heads up about the data.

Thank you.

From: Colleen Creighton
Sent: 8 Jun 2018 19:32:13 +0000
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Lenard, Courtney (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC)
Subject: Re: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Absolutely does. Thanks so much!!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 3:28 PM
To: Colleen Creighton
Cc: Lenard, Courtney (CDC/ONDIEH/NCIPC); Black, Erin (CDC/ONDIEH/NCIPC)
Subject: FW: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Colleen,

I'm responding to your question that Erin shared.

The common substance under 'Other' are something like Acetaminophen, Diphenhydramine, eth. Also, it includes alcohol and ethanol.

We don't have specific substance class for those substance, so they are all under 'Other'.

I hope this helps!

Thanks,

Deb

Deb Stone, ScD, MSW, MPH
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Suicide, Youth Violence & Elder Maltreatment Team
770.488.3942
dstone3@cdc.gov

CDC's Injury Center
Preventing Injuries and Violence Through Science and Action

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 10:15 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: FW: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

See question below re the VS.

From: Colleen Creighton <ccreighton@suicidology.org>
Sent: Thursday, June 7, 2018 5:45 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>

Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin – Thanks so much for the call today and for all your work going into this report. One question that came up from our end is under "Other" – what is included in this category in addition to OTCS?

Other (e.g., over-the-counter)	**1,021 (34.0**

Thanks so much,

Colleen

Colleen Creighton
Executive Director
American Association of Suicidology
5221 Wisconsin Avenue, NW, 2nd Floor
Washington, DC 20015
T: (202) 237-2280, F: (202) 237-2282
Direct: 202-830-3399
Register for FREE trainings here:
www.USMilitaryMatters.org
www.suicidology.org



AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide.
AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research,
education and training, the development of standards and resources, and survivor support services.

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 10:04 AM
To: Torguson, Kimberly <KTorguson@edc.org>; Belyeu, Avery <ABelyeu@edc.org>; jbenson@reingold.com; Bray, Miranda (SAMHSA/OC) <Miranda.Bray@samhsa.hhs.gov>; Sam.Brinton@thetrevorproject.org; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Carr, Colleen <ccarr@edc.org>; SCoggin@afsp.org; Colleen Creighton <ccreighton@suicidology.org>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Curtin, Sally C. (CDC/OPHSS/NCHS) <sac2@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Ashby.Dodge@thetrevorproject.org; mgdyak@eiconline.org; johnd@mhaofnyc.org; fgonzalez@mhaofnyc.org; Gass, Jesse <JGass@edc.org>; Hausman, Bridgette <BHausman@edc.org>; Hedegaard, Holly (CDC/OPHSS/NCHS) <hdh6@cdc.gov>;

Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Amy Kulp <ajkulp@suicidology.org>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; wendy.e.lakso.civ@mail.mil; plauricella@reingold.com; sheri.lunn@thetrevorproject.org; Chris Maxwell <cmaxwell@suicidology.org>; McElroy, James (NIH/NIMH) [E] <james.mcelroy@nih.gov>; McShane, Kristen (SAMHSA/OC) <Kristen.Mcshane@samhsa.hhs.gov>; steve.mendelsohn@thetrevorproject.org; eneely@reingold.com; AOBrien@afsp.org; O'Keefe, Lindsey (NIH/NIMH) [E] ; Amit.Paley@thetrevorproject.org; jpearson@nih.gov; Pearson, Jane L (NIH/NIMH) [E] <jpearson@mail.nih.gov>; Reed, Jerry <jreed@edc.org>; dreidenberg@save.org; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; mrosen@mhaofnyc.org; michaelle.scanlon@nih.gov; Sobottka, Linda <lsobottka@edc.org>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Stout, Elly <estout@edc.org>; calvin.stowell@thetrevorproject.org; AVactor@mhaofnyc.org; Warner, Margaret (CDC/OPHSS/NCHS) <mmw9@cdc.gov>; katherine.v.warrick.civ@mail.mil; kevin.wong@thetrevorproject.org; Wright, James (SAMHSA/DPTSSP) <James.Wright@samhsa.hhs.gov>

Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

In prep for our call today to discuss our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* attached is an **embargoed** copy of the Fact Sheet. The Vital Signs includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions. We appreciate this partnership and hope you can all help us disseminate the Vital Signs to your networks once the **embargo lifts at 1:00 pm**.

Erin

****

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Thank you.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 13:41:22 +0000
To: Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Subject: RE: Embargoed until 1pm June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Thank you! Fingers and toes crossed!!!!

From: Smith, Lakeesha (Shakiyla) (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 9:37 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: FW: Embargoed until 1pm June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Congratulations!! Good luck today! I know you'll rock it!
S

From: Core VIPP (CDC)
Sent: Thursday, June 7, 2018 9:12 AM
Subject: Embargoed until 1pm June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Dear Colleague:
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Thank you for your support.

Debra Houry, MD, MPH
Director
National Center for Injury Prevention and Control

James A. Mercy, PhD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 13:31:27 +0000
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Subject: RE: Embargoed until 1pm June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Thank you.
Deb

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 9:30 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Embargoed until 1pm June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Here you go. Feel free to add your own note before sending to personalize.

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- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 09:14:58 -0400
To: Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Cc: Blair, Janet (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: EMBARGOED UNTIL 1PM June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Thank you Shane. Please let me know if there are any questions from the NVDRS folks that I can help with.

From: Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 9:13 AM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Cc: Blair, Janet (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: EMBARGOED UNTIL 1PM June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Good morning Malia,
The email below was sent to NVDRS PIs at 9:01am. Thank you!
Shane

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 4:36 PM
To: Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Cc: Blair, Janet (CDC/ONDIEH/NCIPC) <zud5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: EMBARGOED UNTIL 1PM June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Shane – Here is the email (below) and attachments to share with NVDRS PIs tomorrow morning at 9am (please do not send out before 9am). As requested by the NVDRS principle investigators, I've also attached internal talking points that they may use if they choose.
Malia
++

Dear NVDRS Principle Investigators:

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older

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Social Media Handles and Twitter Chat:

Please save the date for our upcoming Twitter chat:

The Twitter chat, scheduled for June 11th from 2-3PM ET, will be co-hosted by CDC (@CDCInjury) and The National Action Alliance for Suicide Prevention (@Action_Alliance).

Day: Monday, June 11th

Time: 2:00-3:00PM ET

Place: Twitter.com from your computer or mobile device and search the hashtag #SuicideChat

During the chat, you'll be able to:

- Gain key insights into the most recent @CDCInjury Vital Signs issue
- Ask questions of experts from @CDCInjury and @Action_Alliance
- Share your own prevention resources and stories

Spread the Word

- Tweet: Join the @CDCinjury & @ActionAlliance #SuicideChat on Monday June 11 2-3PM ET. Topics covered include the latest @CDCgov #VitalSigns issue and rates of #suicide in the US.

Additionally, watch for social posts from these handles:

- CDC Facebook
- CDC Twitter
- CDC eHealth Twitter
- CDC Injury Twitter
- CDC VetoViolence Facebook
- CDC LinkedIn
- CDC Google+
- CDC Pinterest
- CDC Instagram (check the stories after 1pm ET)
- CDC Director Twitter

From: Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Sent: 6 Jun 2018 18:14:25 -0400
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Cc: Blair, Janet (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: EMBARGOED UNTIL 1PM June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Awesome! I will not release until 9:01am.
Shane

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 4:36 PM
To: Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Cc: Blair, Janet (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD)
Subject: EMBARGOED UNTIL 1PM June 7: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Shane – Here is the email (below) and attachments to share with NVDRS PIs tomorrow morning at 9am (please do not send out before 9am). As requested by the NVDRS principle investigators, I've also attached internal talking points that they may use if they choose.
Malia
++

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term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

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- CDC Injury Twitter
- CDC VetoViolence Facebook
- CDC LinkedIn
- CDC Google+
- CDC Pinterest
- CDC Instagram (check the stories after 1pm ET)
- CDC Director Twitter

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 4 May 2018 11:58:55 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Fact Sheet revisions-telebrief revisions

No problem, thanks.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 4, 2018 10:20 AM
To: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC)
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) ; Sokler, Lynn (CDC/OD/OADC) ; Omisore, Shannon L. (CDC/OD/OADC)
Subject: RE: Fact Sheet revisions-telebrief revisions

Hi everyone,
Given the urgent need to prepare the next version for Dr. Schuchat, I am going to take out the sentence. I agree with Brandy's point that saying more research is needed takes away from the impact of our other points in that paragraph.
We can consider if there are other ways to address this issue in the FS or other materials. I think the telebrief is a good opportunity.
-Tom

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: Friday, May 4, 2018 10:16 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: RE: Fact Sheet revisions-telebrief revisions

Adding Rich, Lynn, and Shannon.
I don't think the "Although the reasons for the increases need more study" clause is needed for the following reasons:
1) Aside from a couple of topics (ie tobacco), most reasons for increases in disease trends need more study or are multi-factorial. So it's sort of a given. It's the whole "more research is needed" sentence at the end of a discussion section that make ppl cringe. More research is always needed.
2) It makes the reader pause before getting to the meat of the sentence and your SOHCO which is that many factors contribute to suicide. So it water downs one of your main points.
3) We try hard not to start sentences with a prepositional phrase bc it's not clear language and makes the sentence harder to understand, which again will soften the impact of your main SOHCO.
4) Recommend including that the reasons for increases is not fully understood as part of the telebriefing script and Q&As. Media is going to ask your hypothesis for the increases even if you put in the FS, more research is needed.
Thanks,
Brandy

From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Date: May 4, 2018 at 9:15:01 AM EDT
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>, Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: RE: Fact Sheet revisions-telebrief revisions

I think the phrase is useful; without it people will think the contributing factors we list subsequently are responsible for the increases just mentioned. They may be but we don't know. I think it keeps us more honest.
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 4, 2018 8:01 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: RE: Fact Sheet revisions-telebrief revisions

Hi Brandy, Erin, Deb,
We are getting different opinions about the following sentence:
Although the reasons for the increases need more study, many factors are known to contribute to suicide.
Several people have said that we need something like this because there is so much emphasis on the increasing rates we need to acknowledge that we don't know why the increase is happening. We don't have the space to fully describe what people think is happening with the increase. This sentence transitions to the description of circumstances. Others have said it is not necessary.
Do you feel strongly either way?
-Tom

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Thursday, May 3, 2018 6:38 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: RE: Fact Sheet revisions-telebrief revisions

Tom,
That sentence will be added to the FS. Attached are the Word and PDF files. Brandy has reviewed the fact sheet and left some suggested changes. Please read the comments and indicate whether the changes can be made. If you disagree with a suggestion, please delete the comment box or sticky. For the PDF, most of her comments are regarding the graphics on page 3. For example, can "lethal" be changed to "deadly" in the graphic at the bottom of page 3?
Please respond by **Friday, May 4 at 10 a.m.** The fact sheet is going to be sent to OD on Friday, so this would allow enough time for the graphic artist to work on the fact sheet.
Thanks,
Shannon

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 3, 2018 5:25 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; DeNoon, Daniel (CDC/OD/OADC) (CTR) <xlz4@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; DeNoon, Daniel (CDC/OD/OADC) (CTR) <xlz4@cdc.gov>; Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: RE: Fact Sheet revisions-telebrief revisions

Hi Lynn and Shannon,
I had not noticed that the bullets above the pie charts were dropped. Can we still add at least the following bullet to explain what the pie charts mean?
• People without known mental health problems were more likely to be male and to die by firearm.
Otherwise, the pie charts are hard to interpret.
Thank you,
Tom

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 3, 2018 2:21 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; DeNoon, Daniel (CDC/OD/OADC) (CTR) <xlz4@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; DeNoon, Daniel (CDC/OD/OADC) (CTR) <xlz4@cdc.gov>; Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: RE: Fact Sheet revisions-telebrief revisions

Hi Lynn and VS team,
Thank you very much for all your help on the fact sheet and for talking through some important issues this morning. I am attaching a tracked version of the Word document and a version of the pdf with stickies added. Hopefully all of these comments are clear but let me know if you have any questions.
I think the two big issues are:
First, trying to make the top image on page 3 work better. We liked the suggestions you offered on the call to connect the bullets to the boxes by using the same colored font for the first work. Our communications team suggested some other helpful edits.
Second, we'd like to make the two boxes (media and Lifeline) fit on page 4. In the Word document I provided draft examples of the boxes that we hope will work.
We look forward to seeing the next version.
Thank you,
-Tom

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Wednesday, May 2, 2018 12:18 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin

(CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; DeNoon, Daniel (CDC/OD/OADC) (CTR) <xlz4@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; DeNoon, Daniel (CDC/OD/OADC) (CTR) <xlz4@cdc.gov>; Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: Fact Sheet revisions-telebrief revisions

Hi Crystal,

Attached is the revised Fact Sheet for your review. We've done some more work on the telebrief script as well.

So, could you please do the following:

- Provide Fact Sheet graphic changes in stickies on the pdf
- Provide Fact Sheet text changes in the Word document in track changes
- Provide telebrief changes in track changes to the CLEAN document. We need you to provide Dr. Adam's comments to it as well.
- Under separate cover, we provided press release changes that we need you to accept, or edit, and give us back a CLEAN and TRACKED copy. I've reattached here to make it easier for you.

We'd like to have all changes NLT COB tomorrow so that we have Thurs to revise and for your review. In an earlier email I mentioned shorter timeframes. I am thinking that If you have any of these documents ready before COB, please send them along (doesn't have to be in one email). For example, if the Fact Sheet is ready first with edits, please get that back to us so we can give the artist more time for changes. I plan to send everything for the pre-brief out to everyone on Monday.

Thanks much, Lynn

From: Bailey, Keith (CDC/OD/OADC)
Sent: Wednesday, May 2, 2018 10:12 AM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: June VS FS: Changes

Hi Lynn,

Please see updated pdf and word files for June edition of Vital signs.

Thanks,

Keith

Keith A. Bailey
Visual Information Specialist (Design Team)
Graphic Services Branch, Division of Communication Services
Office of the Associate Director for Communication
Centers for Disease Control and Prevention
1600 Clifton Rd, NE (MS G-27) Atlanta, GA 30333
Phone: 404-718-5403
Tour of Duty: 7 A.M.- 3:30 P.M.

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Tuesday, May 1, 2018 3:26 PM
To: Bailey, Keith (CDC/OD/OADC) <okk0@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: June VS FS: Changes

Hi Keith,

Thanks! I will review this in the morning. Please pull the Word file for the May Vital Signs fact sheet.
Shannon

From: Bailey, Keith (CDC/OD/OADC)
Sent: Tuesday, May 1, 2018 3:14 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: June VS FS: Changes

Hi Shannon,
Please find attached, the latest iteration of the June Edition of Vital Signs. Also, please note that all of the suggested edits provided to me, via both pdf and word files, have been applied. Several things are worth mentioning. The photographs pasted into the PDF, by "Program", were treated as a visual guide to use similar ones. For the map on page two, there is the singular use of blue which was broken down into different gradations/tints in response to the comment made about "depth of color".
Here is hoping all is in order to keep things moving along to subsequent phases in the production process.
Thank you,
Keith

Keith A. Bailey
Visual Information Specialist (Design Team)
Graphic Services Branch, Division of Communication Services
Office of the Associate Director for Communication
Centers for Disease Control and Prevention
1600 Clifton Rd, NE (MS G-27) Atlanta, GA 30333
Phone: 404-718-5403
Tour of Duty: 7 A.M.- 3:30 P.M.

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, April 27, 2018 2:26 PM
To: Bailey, Keith (CDC/OD/OADC) <okk0@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: June VS FS: Changes

The changes are for the June VS.

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, April 27, 2018 2:25 PM
To: Bailey, Keith (CDC/OD/OADC) <okk0@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: May VS FS: Changes

Hi Keith,
Attached are changes for the fact sheet indicated in the PDF and Word files. Also attached are the pie charts to replace the current ones and the PowerPoint of the graphic on page 3. Please feel free to contact me with any questions or concerns. To view the graphic at the bottom of page 2 in the Word file, select the simple markup or no markup option. Please update this fact sheet and send to us by the close of business (COB) on Tuesday, May 1.
Thanks,
Shannon

Shannon Omisore, MA
Health Communication Specialist
Office of the Associate Director for Communication
2500 Century Parkway, MS E-21
Atlanta, GA 30345

Office: 404-498-0153
E-mail: hyl5@cdc.gov



From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 4 May 2018 11:13:36 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Fact Sheet revisions-telebrief revisions

Are we over our word limit is that why they are pushing back so much?

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: Friday, May 4, 2018 10:27 AM
To: Black, Erin (CDC/ONDIEH/NCIPC)
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) ; Sokler, Lynn (CDC/OD/OADC) ; Omisore, Shannon L. (CDC/OD/OADC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Fact Sheet revisions-telebrief revisions

Can address increases need more research in telebriefing script to get ahead of question. Also it is in MMWR. Even if you say more research needed in FS, media will ask what are your guesses as to why. I think having it in FS uses up real estate iwith info that doesn't contribute to your main message. But more importantly, it complexes the sentence which takes away from the punch of a definitive statement that "Many factors contribute to suicide."- which is your SOHCO.

From: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Date: May 4, 2018 at 10:18:23 AM EDT
To: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>, Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>, Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>, Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: Fact Sheet revisions-telebrief revisions

I do think a natural question will be WHY are rates increasing so it's helpful to elude to the fact that we don't have all the answers but that more studies are needed (and thus more resources are needed to conduct those studies). If we don't provide this answer ourselves, everyone using our materials will make up their own answer so best to give them the message we think is most appropriate/accurate.

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: Friday, May 4, 2018 10:16 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
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Adding Rich, Lynn, and Shannon.
I don't think the "Although the reasons for the increases need more study" clause is needed for the following reasons:
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Thanks,
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Date: May 4, 2018 at 9:15:01 AM EDT
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Do you feel strongly either way?
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Tom,
That sentence will be added to the FS. Attached are the Word and PDF files. Brandy has reviewed the fact sheet and left some suggested changes. Please read the comments and indicate whether the changes can be made. If you disagree with a suggestion, please delete the comment box or sticky. For the PDF, most of her comments are regarding the graphics on page 3. For example, can "lethal" be changed to "deadly" in the graphic at the bottom of page 3?
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First, trying to make the top image on page 3 work better. We liked the suggestions you offered on the call to connect the bullets to the boxes by using the same colored font for the first work. Our communications team suggested some other helpful edits.
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We look forward to seeing the next version.
Thank you,
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Subject: Fact Sheet revisions-telebrief revisions

Hi Crystal,
Attached is the revised Fact Sheet for your review. We've done some more work on the telebrief script as well.
So, could you please do the following:

- Provide Fact Sheet graphic changes in stickies on the pdf
- Provide Fact Sheet text changes in the Word document in track changes
- Provide telebrief changes in track changes to the CLEAN document. We need you to provide Dr. Adam's comments to it as well.
- Under separate cover, we provided press release changes that we need you to accept, or edit, and give us back a CLEAN and TRACKED copy. I've reattached here to make it easier for you.

We'd like to have all changes NLT COB tomorrow so that we have Thurs to revise and for your review. In an earlier email I mentioned shorter timeframes. I am thinking that If you have any of these documents ready before COB, please send them along (doesn't have to be in one email). For example, if the Fact Sheet is ready first with edits, please get that back to us so we can give the artist more time for changes. I plan to send everything for the pre-brief out to everyone on Monday.
Thanks much, Lynn

From: Bailey, Keith (CDC/OD/OADC)
Sent: Wednesday, May 2, 2018 10:12 AM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: June VS FS: Changes

Hi Lynn,
Please see updated pdf and word files for June edition of Vital signs.
Thanks,
Keith

Keith A. Bailey
Visual Information Specialist (Design Team)
Graphic Services Branch, Division of Communication Services

Office of the Associate Director for Communication
Centers for Disease Control and Prevention
1600 Clifton Rd, NE (MS G-27) Atlanta, GA 30333
Phone: 404-718-5403
Tour of Duty: 7 A.M.- 3:30 P.M.

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Tuesday, May 1, 2018 3:26 PM
To: Bailey, Keith (CDC/OD/OADC) <okk0@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: June VS FS: Changes

Hi Keith,
Thanks! I will review this in the morning. Please pull the Word file for the May Vital Signs fact sheet.
Shannon

From: Bailey, Keith (CDC/OD/OADC)
Sent: Tuesday, May 1, 2018 3:14 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: June VS FS: Changes

Hi Shannon,
Please find attached, the latest iteration of the June Edition of Vital Signs. Also, please note that all of the suggested edits provided to me, via both pdf and word files, have been applied. Several things are worth mentioning. The photographs pasted into the PDF, by "Program", were treated as a visual guide to use similar ones. For the map on page two, there is the singular use of blue which was broken down into different gradations/tints in response to the comment made about "depth of color".
Here is hoping all is in order to keep things moving along to subsequent phases in the production process.
Thank you,
Keith

Keith A. Bailey
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From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, April 27, 2018 2:26 PM
To: Bailey, Keith (CDC/OD/OADC) <okk0@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: June VS FS: Changes

The changes are for the June VS.

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, April 27, 2018 2:25 PM
To: Bailey, Keith (CDC/OD/OADC) <okk0@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: May VS FS: Changes

Hi Keith,

Attached are changes for the fact sheet indicated in the PDF and Word files. Also attached are the pie charts to replace the current ones and the PowerPoint of the graphic on page 3. Please feel free to contact me with any questions or concerns. To view the graphic at the bottom of page 2 in the Word file, select the simple markup or no markup option. Please update this fact sheet and send to us by the close of business (COB) on Tuesday, May 1.

Thanks,

Shannon
Shannon Omisore, MA
Health Communication Specialist
Office of the Associate Director for Communication
2500 Century Parkway, MS E-21
Atlanta, GA 30345
Office: 404-498-0153
E-mail: hyl5@cdc.gov



From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: 4 May 2018 10:28:30 -0400
To: Black, Erin (CDC/ONDIEH/NCIPC)
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID);Sokler, Lynn (CDC/OD/OADC);Omisore, Shannon L. (CDC/OD/OADC);Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Fact Sheet revisions-telebrief revisions

Sorry- emails crossed. Good dialogue team. Brandy

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Can address increases need more research in telebriefing script to get ahead of question. Also it is in MMWR. Even if you say more research needed in FS, media will ask what are your guesses as to why. I think having it in FS uses up real estate iwith info that doesn't contribute to your main message. But more importantly, it complexes the sentence which takes away from the punch of a definitive statement that "Many factors contribute to suicide."- which is your SOHCO.

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- Provide telebrief changes in track changes to the CLEAN document. We need you to provide Dr. Adam's comments to it as well.
- Under separate cover, we provided press release changes that we need you to accept, or edit, and give us back a CLEAN and TRACKED copy. I've reattached here to make it easier for you.

We'd like to have all changes NLT COB tomorrow so that we have Thurs to revise and for your review. In an earlier email I mentioned shorter timeframes. I am thinking that If you have any of these documents ready before COB, please send them along (doesn't have to be in one email). For example, if the Fact Sheet is ready first with edits, please get that back to us so we can give the artist more time for changes.
I plan to send everything for the pre-brief out to everyone on Monday.
Thanks much, Lynn

From: Bailey, Keith (CDC/OD/OADC)
Sent: Wednesday, May 2, 2018 10:12 AM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: June VS FS: Changes

Hi Lynn,
Please see updated pdf and word files for June edition of Vital signs.
Thanks,
Keith

Keith A. Bailey
Visual Information Specialist (Design Team)
Graphic Services Branch, Division of Communication Services
Office of the Associate Director for Communication
Centers for Disease Control and Prevention
1600 Clifton Rd, NE (MS G-27) Atlanta, GA 30333
Phone: 404-718-5403

Tour of Duty: 7 A.M.- 3:30 P.M.

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Tuesday, May 1, 2018 3:26 PM
To: Bailey, Keith (CDC/OD/OADC) <okk0@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: June VS FS: Changes

Hi Keith,
Thanks! I will review this in the morning. Please pull the Word file for the May Vital Signs fact sheet.
Shannon

From: Bailey, Keith (CDC/OD/OADC)
Sent: Tuesday, May 1, 2018 3:14 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: June VS FS: Changes

Hi Shannon,
Please find attached, the latest iteration of the June Edition of Vital Signs. Also, please note that all of the suggested edits provided to me, via both pdf and word files, have been applied.
Several things are worth mentioning. The photographs pasted into the PDF, by "Program", were treated as a visual guide to use similar ones. For the map on page two, there is the singular use of blue which was broken down into different gradations/tints in response to the comment made about "depth of color".
Here is hoping all is in order to keep things moving along to subsequent phases in the production process.
Thank you,

Keith
Keith A. Bailey
Visual Information Specialist (Design Team)
Graphic Services Branch, Division of Communication Services
Office of the Associate Director for Communication
Centers for Disease Control and Prevention
1600 Clifton Rd, NE (MS G-27) Atlanta, GA 30333
Phone: 404-718-5403
Tour of Duty: 7 A.M.- 3:30 P.M.

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, April 27, 2018 2:26 PM
To: Bailey, Keith (CDC/OD/OADC) <okk0@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: June VS FS: Changes

The changes are for the June VS.

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, April 27, 2018 2:25 PM
To: Bailey, Keith (CDC/OD/OADC) <okk0@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: May VS FS: Changes

Hi Keith,
Attached are changes for the fact sheet indicated in the PDF and Word files. Also attached are the pie charts to replace the current ones and the PowerPoint of the graphic on page 3. Please feel free to contact me with any questions or concerns. To view the graphic at the bottom of page 2 in the Word file, select the simple markup or no markup option. Please update this fact sheet and send to us by the close of business (COB) on Tuesday, May 1.
Thanks,
Shannon
Shannon Omisore, MA
Health Communication Specialist
Office of the Associate Director for Communication
2500 Century Parkway, MS E-21
Atlanta, GA 30345
Office: 404-498-0153
E-mail: hyl5@cdc.gov



From: Sokler, Lynn (CDC/OD/OADC)
Sent: 6 Jun 2018 16:16:18 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention

Disregard, just saw that you sent it.

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Wednesday, June 6, 2018 4:16 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention

Sure, we don't usually have one which is why I didn't. Can you send me the final, so I'm sure?

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 4:14 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention

Hi Lynn,
Can you also add the supplementary table?
Thank you,
Deb

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Wednesday, June 6, 2018 2:33 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Gaines-McCollom, Molly (CDC/OPHPR/DEO) <iwg9@cdc.gov>; DeNoon, Daniel (CDC/OD/OADC) (CTR) <xlz4@cdc.gov>; Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>; Hoskins, Sharon (K.D.) (CDC/OD/OADC) <sdh4@cdc.gov>; Iverson, Dontae (CDC/OD/OADC) <liz8@cdc.gov>; Balluz, Lina (ATSDR/DTHHS/OD) <lib7@cdc.gov>; Bonds, Michelle E. (CDC/OD/OADC) <meb0@cdc.gov>; Brand, Anstice M. (CDC/OD/CDCWO) <atb6@cdc.gov>; Brown, Renee (CDC/ONDIEH/NCCDPHP) <ryb8@cdc.gov>; Bumpus, Stefanie (CDC/OID/NCEZID) <wve1@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Burns, Annina (CDC/OD/CDCWO) <vjg7@cdc.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; Clark, Cynthia K. (CDC/OD/OCS) <cfc8@cdc.gov>; Crawford, Carol Y. (CDC/OD/OADC) <cjy1@cdc.gov>; Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>; Das, Mansi S. (CDC/OD/OADC) <hrg7@cdc.gov>; Dempsey, Jay H. (CDC/OD/OADC) <ifb5@cdc.gov>; Diaz, Shelly S. (CDC/OID/NCHHSTP) <erh8@cdc.gov>; Dills, Kimberly C. (ATSDR/OPPE) <kid4@cdc.gov>; DPAID (CDC) <dpaid@cdc.gov>; Dunn, Evelyn (CDC/OCOO/OFR/OA) <edm2@cdc.gov>; Galatas, Kate (CDC/OD/OADC) <kkg2@cdc.gov>; Gonzalez, Belsie (CDC/OD/OADC) <fqi1@cdc.gov>; Grant, Llelwyn (CDC/OD/OADC) <lcg7@cdc.gov>; Green, Hugh (CDC/OD/OCS) <yke8@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>; Heldman, Amy B. (CDC/OD/OADC) <evd4@cdc.gov>; Hogg, Jarrad (CDC/OD/OADC) <isr5@cdc.gov>; Hoo, Elizabeth (CDC/OD/PPEO) <irp5@cdc.gov>; Iademarco, Michael (CDC/OPHSS/CSELS/OD) <mai9@cdc.gov>; Joyner, Tonya (CDC/OSTLTS/OD) (CTR) <wyl6@cdc.gov>; Kelly, Alison (CDC/OCOO/OFR/OA) <ayk7@cdc.gov>; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>; Knight, Dianna (CDC/OD/OADC) <fpz0@cdc.gov>; Knotts, Ashley (CDC/OD/OCS) <vqf0@cdc.gov>; Kroop, Seth (CDC/OD/OCS) <wpw7@cdc.gov>; Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD) <wrm0@cdc.gov>;

Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD) <lym1@cdc.gov>; McGowan, Robert (Kyle) (CDC/OD/OCS) <omc2@cdc.gov>; Olivares, Dagny (CDC/OSTLTS/OD) <dvp2@cdc.gov>; Parikh, Sapana (CDC/OCOO/OFR/OA) <euh8@cdc.gov>; Parker, Stacey M. (CDC/OSTLTS/OD) (CTR) <vgw3@cdc.gov>; Payne, Chelsea C. (CDC/OSTLTS/OD) <cec4@cdc.gov>; Putman, Ami D. (CDC/OPHSS/CSELS/DLS) <ibv5@cdc.gov>; Rasmussen, Sonja (CDC/OID/OD) <skr9@cdc.gov>; Redd, Stephen (CDC/OPHPR/OD) <scr1@cdc.gov>; Redfield, Robert R. (CDC/OD) <olx1@cdc.gov>; Schattner, Aimee (CDC/OD/CDCWO) <xjj4@cdc.gov>; Schindelar, Jessica (CDC/OD/OADC) <ghq1@cdc.gov>; Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; Simon, Gia M. (CDC/OSTLTS/OD) <wpc8@cdc.gov>; Smith, Patti (CDC/OD/OADC) <pab0@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Sorrells, Marjorie J. (CDC/OD/OCS) <isg8@cdc.gov>; Stanojevich, Joel G. (CDC/CGH/OD) <vhi9@cdc.gov>; Ware, Nina (CDC/OD/OADS) <evy5@cdc.gov>; Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID) <aoe8@cdc.gov>; Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR) <kcv7@cdc.gov>; Wilson, Michelle (CDC/OCOO/OFR/OA) <zwv2@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Turner, Cheryl L. (CDC/OD/OADC) (CTR) <ffd0@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>; McGuire, Delaney (CDC/OD/OADC) <mze7@cdc.gov>; Roberts, Ursula (CDC/OD/OCS) (CTR) <nka7@cdc.gov>
Subject: FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention

Hi Folks,

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Vital Signs reaches out to a lot of different people with our topics and, from our evaluation surveys, the uptake out in the field is impressive. In a survey, an astounding **95%** of state health officers and state epidemiologists were aware of and used VS issues, with about 3 in 4 using VS in the past year. All shared the material with their constituents via conference call, e-mail, newsletter, or mailing for topics appropriate to their members. A stratified random sample survey, used with NACCHO member organizations, reported that **74%** of all county or local health departments had heard of or used VS in the past year to educate staff, improve programs, and guide policy formation. As well, a 2017 internal evaluation showed that most program staff involved believe the value derived from it is worth the work, although producing Vital Signs takes a lot of effort.

I want to thank everyone who has worked on this issue for all their extra efforts. It's a very important topic and will be valuable information for many people. We hope that program continues to use this Vital Signs to promote its messages and the recommended actions in it to achieve new results.

Cheers,

Lynn

Lynn A. Sokler|Senior Communication Advisor|Office of the Director|Office of the Associate Director for Communication| Centers for Disease Control and Prevention|Mailing: 1600 Clifton Road MS-E-69| Atlanta, GA 30329| zsz0@cdc.gov| office 404-498-6617 |bus. cell 404-409-5556|fx 404-498-0945


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Saving Lives.
Protecting People.™

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 6 Jun 2018 20:14:19 +0000
To: Sokler, Lynn (CDC/OD/OADC)
Subject: RE: FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention
Attachments: cdc_53785_DS1 (05-21-2018 AM)_clean.pdf

Hi Lynn,
Can you also add the supplementary table?
Thank you,
Deb

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Wednesday, June 6, 2018 2:33 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) ; Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Dorigo, Leslie (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Gaines-McCollom, Molly (CDC/OPHPR/DEO) ; DeNoon, Daniel (CDC/OD/OADC) (CTR) ; Grusich, Katherina (Kate) (CDC/OD/OADC) ; Hoskins, Sharon (K.D.) (CDC/OD/OADC) ; Iverson, Dontae (CDC/OD/OADC) ; Balluz, Lina (ATSDR/DTHHS/OD) ; Bonds, Michelle E. (CDC/OD/OADC) ; Brand, Anstice M. (CDC/OD/CDCWO) ; Brown, Renee (CDC/ONDIEH/NCCDPHP) ; Bumpus, Stefanie (CDC/OID/NCEZID) ; Burden, Bernadette (CDC/OD/OADC) ; Burns, Annina (CDC/OD/CDCWO) ; Charles, Julia (CDC/OD/OCS) ; Clark, Cynthia K. (CDC/OD/OCS) ; Crawford, Carol Y. (CDC/OD/OADC) ; Daniel, Katherine Lyon (CDC/OD/OADC) ; Das, Mansi S. (CDC/OD/OADC) ; Dempsey, Jay H. (CDC/OD/OADC) ; Diaz, Shelly S. (CDC/OID/NCHHSTP) ; Dills, Kimberly C. (ATSDR/OPPE) ; DPAID (CDC) ; Dunn, Evelyn (CDC/OCOO/OFR/OA) ; Galatas, Kate (CDC/OD/OADC) ; Gonzalez, Belsie (CDC/OD/OADC) ; Grant, Llelwyn (CDC/OD/OADC) ; Green, Hugh (CDC/OD/OCS) ; Guest, Megan (CDC/OD/OADC) ; Heldman, Amy B. (CDC/OD/OADC) ; Hogg, Jarrad (CDC/OD/OADC) ; Hoo, Elizabeth (CDC/OD/PPEO) ; Iademarco, Michael (CDC/OPHSS/CSELS/OD) ; Joyner, Tonya (CDC/OSTLTS/OD) (CTR) ; Kelly, Alison (CDC/OCOO/OFR/OA) ; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) ; Knight, Dianna (CDC/OD/OADC) ; Knotts, Ashley (CDC/OD/OCS) ; Kroop, Seth (CDC/OD/OCS) ; Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD) ; Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD) ; McGowan, Robert (Kyle) (CDC/OD/OCS) ; Olivares, Dagny (CDC/OSTLTS/OD) ; Parikh, Sapana (CDC/OCOO/OFR/OA) ; Parker, Stacey M. (CDC/OSTLTS/OD) (CTR) ; Payne, Chelsea C. (CDC/OSTLTS/OD) ; Putman, Ami D. (CDC/OPHSS/CSELS/DLS) ; Rasmussen, Sonja (CDC/OID/OD) ; Redd, Stephen (CDC/OPHPR/OD) ; Redfield, Robert R. (CDC/OD) ; Schattner, Aimee (CDC/OD/CDCWO) ; Schindelar, Jessica (CDC/OD/OADC) ; Schuchat, Anne MD (CDC/OD) ; Simon, Gia M. (CDC/OSTLTS/OD) ; Smith, Patti (CDC/OD/OADC) ; Sokler, Lynn (CDC/OD/OADC) ; Sorrells, Marjorie J. (CDC/OD/OCS) ; Stanojevich, Joel G. (CDC/CGH/OD) ; Ware, Nina (CDC/OD/OADS) ; Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID) ; Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR) ; Wilson, Michelle (CDC/OCOO/OFR/OA)
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Cheers,
Lynn

Lynn A. Sokler|Senior Communication Advisor|Office of the Director|Office of the Associate Director for Communication| Centers for Disease Control and Prevention|Mailing: 1600 Clifton Road MS-E-69| Atlanta, GA 30329| zsz0@cdc.gov| office 404-498-6617 |bus. cell 404-409-5556|fx 404-498-0945



Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30 ¶¶)	+ 34.1 % (23 ¶¶)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3 ¶¶)	+ 46.5 % (4 ¶¶)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Different ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Different ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Different ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

State Abbreviations: AL Alabama; AK Alaska; AZ Arizona; AR Arkansas; CA California; CO Colorado; CT Connecticut; DE Delaware; DC District of Columbia; FL Florida; GA Georgia; HI Hawaii; ID Idaho; IL Illinois; IN Indiana; IA Iowa; KS Kansas; KY Kentucky; LA Louisiana; ME Maine; MD Maryland; MA Massachusetts; MI Michigan; MN Minnesota; MS Mississippi; MO Missouri; MT Montana; NE Nebraska; NV Nevada; NH New Hampshire; NJ New Jersey; NM New Mexico; NY New York; NC North Carolina; ND North Dakota; OH Ohio; OK Oklahoma; OR Oregon; PA Pennsylvania; RI Rhode Island; SC South Carolina; SD South Dakota; TN Tennessee; TX Texas; UT Utah; VT Vermont; VA Virginia; WA Washington; WV West Virginia; WI Wisconsin; WY Wyoming.

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: 17 Jul 2018 21:22:15 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: For Review by COB 8/17: suicide approach summaries for the implementation guidance

Great - thank you both!

From: "Stone, Deborah (CDC/ONDIEH/NCIPC)"
Sent: Tuesday, July 17, 2018 7:31 PM
To: "Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)" ,"Holland, Kristin (CDC/ONDIEH/NCIPC)"
Subject: RE: For Review by COB 8/17: suicide approach summaries for the implementation guidance

Very few comments—look good!
Deb

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Friday, July 13, 2018 3:07 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: For Review by COB 8/17: suicide approach summaries for the implementation guidance

Hello,
We are in the home stretch of completing the implementation guidance for the TP's. One component of the guidance pertains to the specific approaches in the technical packages. We are down to the last 8 summaries – 7 of them are specific to the suicide TP. We put these on hold until after the Vital Signs – for obvious reasons!
Attached are 3 short ones for your review.
Lindsey is hoping to get this last batch into clearance ASAP – we are up against a contract deadline with Banyan. If you could review and send any comments/suggestions on the three attached by Tuesday COB, I'll incorporate your changes and get them ready for clearance.
The other ones that we need to finalize include:

- Postvention
- Safer suicide care through system change
- Treatment for people at risk of suicide
- Treatment for victims/survivors (which includes content across the technical packages)

Please let me know if you have any questions.
Thanks in advance for your help!
Linda

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 17 Jul 2018 23:31:45 +0000
To: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: For Review by COB 8/17: suicide approach summaries for the implementation guidance
Attachments: SUI_Crisis Intervention - for SME review ds.docx, SUI_Gatekeeper Training - for SME review ds.docx, SUI_Peer Norm Programs - for SME review ds.docx

Very few comments—look good!
Deb

From: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Sent: Friday, July 13, 2018 3:07 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: For Review by COB 8/17: suicide approach summaries for the implementation guidance

Hello,
We are in the home stretch of completing the implementation guidance for the TP's. One component of the guidance pertains to the specific approaches in the technical packages. We are down to the last 8 summaries – 7 of them are specific to the suicide TP. We put these on hold until after the Vital Signs – for obvious reasons!
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Please let me know if you have any questions.
Thanks in advance for your help!
Linda

Crisis Intervention

This approach focuses on providing support and referral services, typically by connecting a person in crisis to trained volunteers and professional staff. Crisis intervention approaches are intended to impact key risk factors for suicide, including feelings of depression, hopelessness, and subsequent use of mental health care services. Crisis intervention can also put space and time between an individual who may be considering suicide and harmful behavior.

Strategy

- **Identify and Support People at Risk** (Suicide)

Key Objectives	• Provide critical support and services to persons at risk of suicide • Reduce risk factors for suicide
Implementation Considerations	• Crisis intervention services may be accessed through a telephone hotline, online chat, text messaging, or in-person • Education and awareness about how to seek help may also be made through public service announcements, billboards, brochures, and other materials in the offices of primary care and other providers • Duration of the intervention support varies depending on type of service and the immediate and long-term needs of the client • Some crisis intervention programs use trained volunteers; others use licensed professional staff
Sector Engagement	• Public health • Social services • Community organizations
Example Outcomes	• Reductions in ○ feelings of hopelessness ○ psychological pain ○ intent to die
Additional Resources	• Best Practices (Suicide Prevention Lifeline) - https://suicidepreventionlifeline.org/best-practices/ • Crisis Center Accreditation Program - http://www.suicidology.org

Example Programs/Practices/Policies:

- National Suicide Prevention Lifeline (Suicide)

Example Programs

National Suicide Prevention Lifeline (Suicide)

Description: The National Suicide Prevention Lifeline is a national network of local crisis centers that provides support to people in suicidal crisis or emotional distress. It also provides resources to family members and friends and best practice resources for professionals. The hotline operates 24/7 and is accessible by phone or a web-based chat function. Trained counselors are on-hand to listen, offer free and confidential emotional support, and provide referrals for mental health services in the local area.

Specific Populations/Settings	Key Partners	Considerations
• Population(s): Individuals in suicidal crisis or emotional distress • Setting(s): Virtual setting via telephone and/or web-chat	• Community organizations • Mental health providers • Health care providers • Public health agencies	• Lifeline Network Crisis Centers are accredited and follow written policies and guidelines addressing referral, training, and suicide risk assessment • Many centers offer other services, including training and educational resources in suicide prevention and wellness for their local communities • Crisis centers that are part of the National Lifeline Network also participate in Lifeline evaluation activities

Additional Information

- National Suicide Prevention Lifeline - https://suicidepreventionlifeline.org/

Gatekeeper Training

This approach focuses on training individuals such as teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others in the community to identify and respond effectively to people who may be at risk of suicide. By identifying people at risk of suicide and linking them to appropriate support and care, gatekeeper training can positively impact suicide and risk factors for suicide such as depression and feelings of hopelessness.

Strategy

- **Identify and Support People at Risk** (Suicide)

Key Objectives	• Improve ability of gatekeepers to identify and understand the warning signs of suicide • Learn how to intervene appropriately and help people at risk of suicide • Increase knowledge of available resources and support
Implementation Considerations	• Programs may be implemented in a variety of settings (e.g., schools, university/campus, healthcare, community, military) • Many programs include specific guidance for the nature and sequencing of content to help gatekeepers feel comfortable with recognizing and inquiring about risk and facilitating access to support and care • Programs are often delivered in groups and use a combination of methods (e.g., group discussion, audiovisual learning aids, presentations, role-playing) to provide opportunities to engage participants and practice skills • Training requirements vary depending on specific program model, ranging from a few hours to 2-5 days • Evidence of effectiveness also varies for different programs so it is important to review the evidence supporting a specific program before selecting one to implement
Sector Engagement	• Public health • Healthcare • Education • Government • Community organizations
Example Outcomes	• Reductions in ○ suicide ~~deaths~~ ○ suicide attempts ○ depression ○ feelings of hopelessness
Additional Resources	• Comparison Table of Suicide Prevention Gatekeeper Training Programs (Suicide Prevention Resource Center) http://www.sprc.org/sites/default/files/migrate/library/SPRC_Gatekeeper_matrix_Jul2013update.pdf

Example Programs/Practices/Policies:

- Applied Suicide Intervention Skills Training (Suicide)
- Garrett Lee Smith Suicide Prevention Program (Suicide)

Comment [zaf9]: Could drop this phrase. It's a little confusing.

Comment [zaf9]: Maybe say from a few hours to 1 or more days?

Example Programs

Applied Suicide Intervention Skills Training (ASIST) (Suicide)

Description: ASIST is a training program for hotline counselors, emergency workers, clergy, caregivers and others in the community. The ASIST model has three phases of caregiving: connecting, understanding and assisting. In the first phase (connecting), participants learn how to identify people who are having thoughts of suicide. In the second phase (understanding), participants learn how to recognize the caller's invitation for help and how to listen to the caller's reasons for dying and living. In the third phase (assisting), participants learn how to conduct a safety assessment, develop a safety plan for the person at risk, and connect the person at risk to community resources. The ASIST training program has been field tested in a variety of settings.

Specific Populations/Settings	Key Partners	Considerations
• Population(s): Persons at risk of suicide • Setting(s): School, community, military	• Community organizations • Healthcare providers • Emergency medical services • Faith-based organizations • Government (local, state, federal) • School administrators and staff • Public health agencies	• 2-day training workshops are required to deliver the ASIST program • Materials and consultation support are available • Program cost available online

Additional Information

- ASIST Program Site - https://www.livingworks.net/programs/asist/
- Program Summary (SPRC) - http://www.sprc.org/resources-programs/applied-suicide-intervention-skills-training-asist

Garrett Lee Smith (GLS) Suicide Prevention Program (Suicide)

Description: Gatekeeper training is a core component of the Garrett Lee Smith (GLS) Suicide Prevention Program which has been implemented in states, territories, tribal communities, and college campuses across the United States. The program is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Individuals are trained to better recognize the risk for suicide, inquire about risk, intervene appropriately, and help the suicidal individual obtain assistance. Training ranges from a few hours to a few days.

Populations/Settings	Key Partners	Considerations
• Population(s): Persons at risk of suicide • Setting(s): School/college campuses, community	• Community organizations • School/campus administrators and staff • State mental health agencies • Government (local, state, federal) • Tribal communities • Public health agencies	To find the state or local GLS grantees in your community visit this website.

Additional Information

- SAMSHA – Garrett Lee Smith Suicide Prevention Program – http://www.samsha.gov

Peer Norm Programs

This approach seeks to make protective factors for suicide such as help seeking, reaching out and talking to trusted adults, behaviors that are normal and acceptable. It also focuses on promoting connectedness among peers, which can increase belonging, reduce isolation, build resiliency, and encourage adaptive coping behaviors. By leveraging the leadership qualities and social influence of peers, peer norm approaches are an important way to shift group-level beliefs and promote positive social and behavioral change.

Strategy

- **Promote Connectedness** (Suicide)

Key Objectives	• Increase connectedness among peers and promote positive norms that protect against suicide • Strengthen bonds to schools, peers, and adults • Strengthen youth's leadership and social influence skills • Improve communication between youth and trusted adults
Implementation Considerations	• Programs are primarily delivered in school settings but may also be implemented in community settings • Programs are designed to be developmentally appropriate for youth in middle, high-school, and college • Programs are often delivered in groups and include social norm campaigns and active learning experiences to reinforce program concepts • Involving parents, school staff, or community members may also be important, depending on the specific program model • Implementers may need specialized education, training or certification, depending on the program
Key Stakeholders	• Public health • Education • Community organizations
Example Outcomes	• Increases in ○ healthy coping attitudes and behaviors ○ referrals for youth in distress ○ help-seeking behaviors ○ positive perceptions of adult support
Additional Resources	

Example Programs/Practices/Policies:

- Sources of Strength (Suicide)

Comment [DLL(]: Any suggestions for good, general resources to include here?

Comment [zaf9]: The only thing I could find is from veto violence. Relevant? https://vetoviolence.cdc.gov/violence-prevention-basics-social-norms-change

Example Programs

Sources of Strength (Suicide)

Description: Sources of Strength is a youth suicide prevention project designed to use peer social networks to change unhealthy norms and culture. The mission of Sources of Strength is to prevent suicide by increasing help seeking behaviors and promoting connections between peers and caring adults. The program trains peer leaders, as well as adult advisors, to conduct messaging activities aimed at changing peer group norms around coping practices and problem behaviors. In addition, the program is designed to have a positive influence on the knowledge, attitudes and behaviors of the peer leaders.

Specific Populations/Settings	Key Partners	Considerations
• Population(s): Adolescents and young adults (ages 13-24 years) • Setting(s): School, community	• Public health agencies • School administrators and teachers • Community organizations	• Training and certification is required to deliver the program • Training materials, videos, and other resources are available • Consultation and technical assistance are available • Program cost available

Additional Information

- Sources of Strength Program Site - https://sourcesofstrength.org

From: /o=cdc/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=f43dd520d1854120aa942ac284dc7713-discoverysearchmailb
Sent: 25 Apr 2018 02:17:05 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: FOR REVIEW: Vital Signs Communications Products

Two more edits:
Initially I thought don't include the following but instead I expanded on it:
While all decedents were predominately male (76.8%) and non-Hispanic white (83.6%), those without known MHP, relative to those with MHP, were more likely male (83.6% vs. 68.8%; odds ratio (OR)=2.3, 95% CI = 2.2-2.5) more likely racial/ethnic minorities (OR range: 1.2-2.0), and more likely to die by firearms (OR=1.6, 95% CI= (1.5-1.7). Overall, the large majority of suicides occurred among people ages of 25-64.
Related to your comment in the TB to "to add some text here or below from the MMWR conclusion that connects these results back to the need for broader prevention and the TP. " here's the paragraph now:

More than half of suicide decedents in NVDRS did *not* have a known mental health problem. This group suffered more from relationship problems and other life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises, however such circumstances were also common in people with mental health problems. To address the full range of contributing factors to suicide, comprehensive suicide prevention activities are needed. Such strategies include both upstream prevention to prevent risk from occurring in the first place as well as more downstream activities responsive to the needs of people at increased risk and to prevent re-attempts. The CDC's technical package to prevent suicide provides such a broad approach.
Did the study provide recommendations for prevention?
Comprehensive suicide prevention activities are needed to address the full range of factors contributing to suicide. For example, among people with mental health problems, the study identified a need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to providers in underserved areas is needed, as is expansion of healthcare systems needed that integrates physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions.
In addition to strategies addressing mental health problems, the study identified the need for attention to the broader range of circumstances contributing to suicide, including relationship, substance use, physical health, job, financial, and legal problems. Together a comprehensive approach to suicide includes (7 strategies from tp here).

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Tuesday, April 24, 2018 5:23 PM
To: Bruce, Crystal (CDC/OPHPR/OD) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Ballman, Marie R. (CDC/ONDIEH/NCIPC)
Subject: RE: FOR REVIEW: Vital Signs Communications Products

Hi Crystal,
I have some comments in each. I discussed them with Deb and I'm ccing her on this email so that she can start working on them so that you can meet the goal of sharing these with Leslie tomorrow. I told Deb that we might have more time on the Q&A but she is going to start to answer the questions I added and pull in some more examples from existing Q&A. This way we will have them if we need to send on Friday and Leslie can see them too.
Thank you, Tom

From: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Sent: 21 Jun 2018 14:01:15 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

Ok coming over in a sec!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 21, 2018 2:00 PM
To: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

I'm in the office.

From: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 21, 2018 1:59 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

Are you in office today? Or I call you?

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 21, 2018 1:58 PM
To: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

Hey. So what happens if you don't highlight SOS? Can you highlight a different program?
Looks like the impact of SOS was just at 3 mos follow-up and didn't increase help-seeking or decrease suicide ideation (but decreased attempts?).
May not be the best program to highlight. Could highlight the youth aware of MH program or good behavior game (which also has some issues).
Deb

From: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 21, 2018 10:49 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

Ok – I will hit pause on this story until I hear back from you?

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 21, 2018 10:49 AM
To: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

I need to re-read this article. This is why it wasn't included in the technical package.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4357329/
Deb

From: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 21, 2018 10:04 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

Found out we don't even need to ask Linda. Just because a program wasn't included as an example doesn't mean that it might not be evidence-based or based on best-available evidence. (The TP only provided a small number of examples of programs and is not exhaustive). We can use this story if it gets through clearance!! Will follow up with more soon.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, June 18, 2018 3:55 PM
To: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

Here's my review of the two documents. Have we heard back from Linda Dahlberg yet? I need to try and find out why we didn't include SOS in the tp. Seems odds to highlight in this video if it's not included in the tp.

Deb

From: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Sent: Monday, June 18, 2018 10:24 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

Thank YOU

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, June 18, 2018 10:23 AM
To: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

Ok, thanks!!

From: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Sent: Monday, June 18, 2018 10:23 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

Nope, but this is the same item that I resent to you last week (with updates) – so may want to use more recent doc

---

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Sent: Monday, June 18, 2018 10:21 AM
To: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

Reviewing this today. Is it too late?

From: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Sent: Tuesday, June 5, 2018 10:44 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Subject: For SME review AFTER VITAL SIGNS IS OVER :)

Hey Deb,

Please feel free to file this away until after the Town Hall! I am excited to present a creative brief for a video to help demonstrate how everyday heroes (regular people!) can implement strategies and approaches from our technical packages to prevent violence. This story is from Ohio and is focused on preventing youth suicide.

Please let me know if you have questions. If you could turn this back around before you go on leave in June, that would be wonderful! I have left in some comments from our new PMF, Morgan, to show you our thinking.

Thanks,

Molly

From: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Sent: 18 Jun 2018 18:23:08 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

Haven't asked Linda yet...this hasn't even been to ADS yet. Thank you!!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, June 18, 2018 3:55 PM
To: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)

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Thanks,
Molly

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 18 Jun 2018 19:55:19 +0000
To: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: For SME review AFTER VITAL SIGNS IS OVER :)
Attachments: John Ackerman Signs of Suicide_Creative Brief_5.17.18_MK_VD_MT ds.docx, SuicideVideoMotionGraphicScript_ak_6_6_18 _HCET feedback for SME review ds.docx

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Thanks,

Molly

DVP Technical Package Video: John Ackerman/Signs of Suicide

CDC SME reviewer: Deb Stone
Video Creative Brief

Story Overview

Youth suicide is a growing public health concern. In 2016, in the United States, ~~it~~ suicide is the second ~~third~~ leading cause of death for young people aged 10-24 years old and results in 6,159~~4,600~~ lives lost each year. Suicide is rarely caused by any ~~one~~ single factor, and therefore, comprehensive prevention is essential.

In Ohio, Nationwide Children's Hospital, one of the largest behavioral health centers in the country, is working to better understand and create solutions to reduce suicide among children and teens. In 2015, the hospital created the Center for Suicide Prevention and Research (CSPR) both to serve as a suicide prevention resource for youth, parents, schools, clinicians, and community partners, and to help address gaps in prevention services. CSPR has also developed a proactive prevention program, Signs of Suicide (SOS), for middle and high school students. SOS aims to dispel misunderstandings about suicide, teach students (and the community) about depression and the warning signs of suicide, and connect those at risk to support services. The program also helps schools develop gold-standard safety plans for at-risk youth.

John Ackerman, a clinical child psychologist, leads the SOS program at CSPR. He underscores the need for proactive prevention programs. John works with children and teens with mood and anxiety disorders, and has conducted extensive research on gaps in local trend data and suicide prevention programs. He believes that the extent of suicide is underestimated by data: many more people experience suicidal thoughts, make suicide plans and nonfatal suicide attempts than the data suggest.

In 2016, John and his team of clinicians partnered with Screening for Mental Health, a nonprofit organization, to set up SOS in 88 schools across 12 counties in central Ohio. Approximately, 23,350 students participating in the program were screened for suicide and depression. The screenings revealed that more than 800 students were at increased risk for suicide. John's team conducted lethality assessments (which measure risk of fatal violence) on the 800 students. Of the 800 students, 118 required urgent crisis referrals (outpatient crisis care within 48 hours or hospitalization); the remaining students received outpatient or school-based mental health referrals.

John has also partnered with other suicide prevention groups to establish guidelines to help journalists and social media practitioners write about suicide in ways that honor the experiences of survivors without sensationalizing them. He has shared the guidelines with many media outlets, including the Columbus Dispatch and Self.com, and reports that journalists have embraced the guidelines. In addition, the American Association of Suicidology is working to convert the guidelines into an easy-to-use toolkit for journalists. The toolkit will reside on the association's website.

Linkage to the Technical Package

Suicide Prevention Technical Package

- Create Protective Environments
- Lessen harm and prevent future risk (safe reporting and messaging about suicide)
- Promote connectedness

Comment [KMR(]: Check data year

Comment [DVM(]: Did we ever check with Linda D. about this program and if okay to mention?

Comment [KMR(]: Not yet.

Comment [zaf9]: What did Linda say as we decided not to include this in the technical package. I've forgotten now why exactly we didn't include. I think there was some questioning of the results.

Comment [TM(]: How does this link to his SOS and preventative work? Seems only to highlight the potential greater scope of the problem, which is good but doesn't help understand why *preventative* approaches are necessary.

Comment [TM(]: Missing the inciting incident—in the summary it describes increasing suicide rates and John's new job title and research into data gaps. I don't think we need everything from the summary, but *we do need to know why he began this work.* (The "Why now?" story question.)

Comment [TM(]: This is the story we're telling, as I understand it from this brief. Specific to SOS.

Comment [TM(]: They received outpatient referrals? I think I understand, but this could be clearer—they were referred for outpatient or school-based mental health services?

Comment [TM(]: A sentence explaining why this is important (results section from summary)? Hopefully that will be clear in the video.

Comment [DVM(]: Do we have an ability to cross check their guidelines with the reporting on suicide guidelines?

Comment [zaf9]: Wondering if these are the same guidelines as the current guidelines—maybe CSPR worked with AFSP and the other orgs to put the current guidelines together?

- Identify and support people at risk

Story Goals

The goal of this project is to demonstrate that everyday heroes can carry out technical package strategies and approaches to prevent suicide. The video will have these primary purposes:

1. Highlight ways that data can be used to identify gaps in existing programs in order to select strategies and approaches to fill the gaps.
2. Emphasize how a program that started in a health care system recognized the need for greater primary prevention.
3. Feature successful school-based suicide prevention interventions.

Interview Guide

Interview guides can help direct the interviewee toward the topics and issues you want to learn more about. The questions below are samples:

- How does SOS help schools develop gold-standard safety plans for high-risk youth? What's involved, and how do you ensure consistent implementation?
- What methods were used to identify/choose schools or school districts to pilot the program?
- How have students responded to SOS?
- What challenges, if any, did you face in setting up SOS at schools?
- What does the data show about the relationship between SOS and youth suicide?

Video Approach

STYLE

We propose an animation with voice-over style to help explain John's research and data.

MAIN FOCUS/VOICE

The main focus is the voice of a narrator.

STORY FLOW

John Ackerman is featured as an animated character. The narrator will guide the viewer through personal experiences with setting up suicide prevention strategies in schools and describing research findings. The video will be driven by data and will highlight key findings with evidence-based stories, helping to bring statistics to life. Through this narration, we hope to bring to light the importance of suicide prevention and awareness and hear primary prevention successes.

Comment [TM(]: If this can be made specific to one school, as an example, the story will be more clear. Singular more powerful and specific than plural.

Comment [TM(]: Okay, but the story can't be driven by data. The story needs to be driven by *John* and the gap he saw and filled.

Suicide Motion Graphic Video
RT 00:30-00:45

We open on flashing text that appears on the top left side of the screen over a B&W image.

(*Note: Text that refers to the problem appears on top left of the screen while CDC solutions appear on the bottom right…over the same image)

TOS:
Suicide is a serious public health problem and the 10th leading cause of death in the United States.

Image remains on the screen.

TOS: It hurts families, communities, and society at large. (possibly overlay drawing SEM)

NEW IMAGE APPEARS

TOS top left: The causes of suicide are numerous ~~and complex~~.

TOS (on the bottom right of the image): **But Suicide is Preventable.**

TOS over same image: CDC is dedicated to using a ~~broad~~comprehensive, public health approach to ~~prevent~~ suicide prevention.

NEW IMAGE APPEARS

TOS: CDC monitors, tracks, and ~~describes~~ ~~examin~~~~investigates~~ the growing problem of suicide.

Same image remains

By conducting and supporting research to understand the underlying causes of suicide, CDC works with partners to ~~helps~~ identify, develop, and test new app~~far-reaching~~ prevention strategies.

NEW IMAGE APPEARS

TOS bottom right: Strategies like developing programs that target risk and protective factors at all levels – individual, relationship, community, and society – of the social ecological model~~SEM~~.

TOS: Strategies like fostering community connectedness, and creating opportunities to access to health care and social support systems.

NEW IMAGE APPEARS:

Comment [zaf9]: I was told we aren't supposed to say complex since this implies it's too hard to fix or prevent.

Comment [BMR(]: Or examines?

Comment [zaf9]: Yeah, I might say examines instead. While investigate isn't wrong I wonder if it may send the message that we are out in the field every day.

Comment [KMR(]: Not sure if this is needed/honest, considering that we have no way to know this.

Comment [BMR(]: Is CDC developing and testing? And agree with Molly's comment above about removing far-reaching.

Comment [zaf9]: This could be two things. We conduct research is one aspect and then I'd say we work with partners to identify…). The way the sentence is worded now with the edits it doesn't flow right. Maybe y'all can fix this.

Comment [zaf9]: This seems a little overstated. How about creating opportunities?

TOS on bottom right: CDC's goal is to prevent suicide and save lives by ~~reducing risk factors and increasing protective factors~~**in order to support the nation in reaching its goal to reduce the annual suicide rate 20% by 2025**.

NEW IMAGE

TOS in MIDDLE OF SCREEN: ~~By working together (would be nice to see flashing words of who "we" are: local and state public health organizations, education systems, businesses, public health, justice and social service sectors), we can~~Together we can prevent suicide.

website.com

Comment [KMR(]: I think this part should refer to the National Strategy for Suicide Prevention: goal of reducing the annual suicide rate 20 percent by 2025

Comment [)]: I like this idea.

Comment [KMR(]: Sounds nice, but if this video is meant to carve out CDC's niche in suicide prevention, it could be muddled. Marie agrees.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 19 Apr 2018 10:50:25 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: For Your Review: **VS quick turnaround** Communication Pieces
Attachments: PR_V1_4.17.18.03.15pm_CB_MRB ds.DOCX, TB_V1_4.17.18.03.15pm_CB_MRB ds.DOCX, DC_V1_4.17.18.03.15pm_CB_MRB ds.DOCX, CC_V1_4.17.18.03.15pm_CB_MB ds.DOCX

Hi Deb,
I think your input is fine. I actually encourage you to be critical at this point and really be certain that you can defend each point, particularly those in the script and PR. I only had 30 minutes to skim this and didn't get through everything but I added some initial comments for you to consider.
One thing that I think we should do is list the other contributing factors when appropriate so people have a sense of what we mean. I'm thinking about some variations on the following: "Knowing the many factors in addition to mental health concerns that contribute to suicide risk such as relationship problems, crises, substance use, poor health, job/financial problems, arguments or conflicts, and legal problems can help us identify and support people at risk of suicide."
Best,
-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, April 19, 2018 12:20 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: For Your Review: **VS quick turnaround** Communication Pieces

Hi Tom,
I received the 4 comm items noted below today. I found myself having a lot of comments and was wondering if you might help me by looking at what I've commented on and letting me know your thoughts? Am I being too critical or getting too far a field?? Or am I on the right track? I just don't want to start changing things as I'm prone to do without another set of eyes seeing my train of thought. (as a reminder, I'm supposed to review in a day and send to Malia and then she reviews and sends to you—I think if you and I can do a tag team review it might be more efficient, i.e. if you and I review together it can save time when the documents get to you).
I'm not able to be on my work computer so easily here art AAS, so maybe if you can text me after you've replied/reviewed my comments then I'll know when to login. Sorry to be so high maintenance!! I know you are super busy.
Thanks,
Deb

(b)(6)

[redacted]

P.S. The MMWR was cleared and cross-cleared now. I just need to upload the version we sent to the VS office into e-clearance. I hope we'll get OD comments soon!

From: Ballman, Marie R. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 18, 2018 6:57 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: For Your Review: **VS quick turnaround** Communication Pieces

Deb,
Attached are the Vital Sign Communication documents for your review in one day to keep us on track for our deadline. Note, that these adhere and stick very closely to the fact sheet and Q&A pulls from the MMWR itself.
Documents included are:

- Press Release
- Dear Colleague Letter
- Tele-briefing Script with Q&A
- Critical contacts with email

Please note that there is a list at the top. Please add your review date next to your name. The list will be taken off before sending to Vital Signs office but thought it would be a good internal tracking double check.
Also, let Crystal or I know if you have any questions or concerns.
Thanks,
Marie

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, April 13, 2018 5:03 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>
Cc: Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: **Head's up for next VS quick turnaround**

Hi Everyone,
Happy Friday and hope you are doing well. I just spoke with Marie and got an update on the next steps in the VS process as it relates to comm/policy.
As with the clearance of the MMWR and the fact sheet, we are once again on a super fast review timetable. Marie has outlined below what is needed and by when. I think the process makes good sense. As Marie mentions, all of the materials you will be receiving are based on the cleared MMWR and fact sheet, so the review should go quickly (knock on wood). I really appreciate everyone's commitment to making this Vital Signs a priority (not to mention the best DVP one yet!). ;)
Best,
Deb
P.S. for everyone cc'd this is just to keep you in the loop!
****

Here is the communication update. Our plan and hope is to have the following pieces **ready for review by next Wednesday, April 18, 2018:**

- Press Release
- Dear Colleague Letter
- Tele-briefing Script with Q&A
- Critical contacts with email

These items (all based on the cleared Vital Signs factsheet) **are due to the Vital Signs office on April 27, 2018.** The plan is to bundle the items listed together for each reviewer. The thought here is that we can all then ensure we are being consistent across documents. We do ask that reviewers resolve any conflicts before returning documents or passing on to the next reviewer. This is to ensure the documents don't get to the end and need to circulate back through. There will be a really tight turn around for each reviewer of a day. This is to ensure we have (fingers crossed) April 27, 2018 to clean it all up and hit the send button. We realize this is really tight but would appreciate everyone sticking to the proposed timeline.

Comm proposes these reviewers in this order:

- Marie Ballman, communication review on April 19, 2018
- Deb Stone, SME review on April 20, 2018
- Malia Richmond-Crum, policy review on April 23, 2018
- Tom Simon, ADS on April 24, 2018
- Jim Mercy, DVP director on April 25, 2018
- Leslie Dorigo, NCIPC OC, ADC on April 26, 2018

Please let me know if you have any questions or concerns with the plan.
I truly appreciate everyone's assistance and effort on this Vital Signs release.
It is going to be fabulous!
Cheers,
Marie

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 11, 2018 4:53 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Cc: Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Subject: RE: Vital Signs Prep Meeting

Hi Everyone,
It looks like most people will be out next Tuesday at EIS so I cancelled our meeting. I will follow up with the MMWR group related to any feedback we get back from CDC OD.
I'm guessing the same will be true for Tom and the factsheet group. If it's needed, I may reschedule us for 4/24 so if you could hold that date at noon that would be great.
Crystal, if you don't mind sending an email update to everyone about comm/policy progress that would be great too (by next Tuesday?). I know you all have been doing a lot so I want to make sure that everyone is up to speed. Thanks so much!
If anyone has any questions, please contact me.
Deb

Review Tracker

- NCIPC OC Leslie Dorigo:
- DVP ADS Tom Simon:
- DVP Policy Malia Richmond-Crum:
- DVP SME Deb Stone:
- DVP HCET Marie Ballman: 4/17/2018

Press Release

Embargoed until 1:00 pm ET

Tuesday, June 5, 2018

Contact: CDC Media Relations

404-639-3286

Rising suicide rates across states

Rates increased more than 30% in half of states, while most other leading causes of death declined.

Suicide is a leading cause of death in the U.S. and is on the rise in 44 states, according to the latest Vital Signs report by the Centers for Disease Control and Prevention (CDC). In 2016, nearly 45,000 people age 10 or older died by suicide.

This report examines suicide deaths at the state level from 1999 to 2016. Notably, mental health problems are just one factor contributing to suicide. "Mental health problems are often cited as *the* cause of suicide, but suicide is rarely caused by only one factor," said [SPOKESPERSON]. "In fact, many people who die by suicide are not known to have mental health problems at the time of death".

Many factors contribute to suicide

For this *Vital Signs* report, CDC examined state-level trends in suicide rates between 1999-2016. In addition, they used data from the National Violent Death Reporting System [add hyperlink], which covers 27 states, to look at the circumstances of suicide deaths among people with and without known mental health problems. The researchers found that more than half of people who died by suicide did not have a known mental health problem. This group suffered more from relationship problems and other life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises, however these circumstances were common to people with and without mental health problems. Firearms were the most common method of suicide used in both groups.

Wide range of prevention activities needed

Comment [zaf9]: I wouldn't include this. Rates increased more than 30% over the period 1999-2016, other leading causes of death decreased over the past few years I believe (and we didn't look at those rates in our study). I'd rather just say between 1999-2016 suicide rates increased by more than 30% in half of all states.

Comment [zaf9]: I'm not sure we need to say this here??

Comment [ST(]: I would keep it.

Comment [ST(]: This transition is awkward. It makes it sound like the circumstance analysis is at the state leve.

"We need comprehensive statewide suicide prevention activities to address the full range of factors contributing to suicide." [SPOKESPERSON] added, "There are opportunities for prevention every day. Close coordination of government, business, education, faith, and the media sectors are important for preventing suicide." In addition, everyone can:

- ~~Reduce access to lethal means, such as medications and firearms, among people at risk.~~
- Learn the warning signs of suicide to help identify and refer people at risk.
- Contact the National Suicide Prevention Lifeline for help for themselves or others: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org/

Vital Signs is a CDC report that typically appears on the first Tuesday of the month as part of the CDC journal Morbidity and Mortality Weekly Report. The report provides the latest data and information on key health indicators. These are cancer prevention, obesity, tobacco use, injury prevention, prescription drug overdose, HIV/AIDS, alcohol use, healthcare-associated infections, cardiovascular health, teen pregnancy, and food safety.

###

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Comment [zaf9]:

Comment [ST(]: I'm not a fan of this language. I'm not sure what this means in practice and we could be asked that.

Comment [ST(]: Suggest either dropping from the PR or moving this down to raise the profile of the others.

Comment [zaf9]: Might be nice to reference the bethe1to..

Review Tracker

- NCIPC OC Leslie Dorigo:
- DVP ADS Tom Simon:
- DVP Policy Malia Richmond-Crum:
- DVP SME Deb Stone:
- DVP HCET Marie Ballman: 4/17/2018

Vital Signs Rising Suicide Rates Across U.S.

June 7, 2018

Desired Headlines

- Nearly 45,000 suicides occurred in 2016, but suicide is preventable.
- Suicide rates increased more than 30% in half of U.S. states since 1999.
- Many factors other than mental health problems contribute to suicide.

Moderator: Thank you (OPERATOR NAME). And thank you all for joining us today for the release of a new CDC Vital Signs. We are joined by CDC Director Dr. Robert Redfield, as well as Dr. Ann Schuchat, CDC's Deputy Director. Dr. Redfield is unavailable to stay for the media Q&A portion of the briefing, so Dr. Schuchat will take your questions. I'd like to turn the call over now to Dr. Redfield.

Dr. Redfield

- Good afternoon and thank you for joining us today.
- CDC provides for the common defense of the country against health threats. Each month in our Vital Signs report, we focus on a public health threat from the front lines and give you information to help stop it.
- Today's report contains **new information about rising suicide rates across the U.S.** Let's start with the good news.
- There are **opportunities for preventing suicides** every day. Knowing the many **factors** ~~other than~~in addition to mental health ~~issues~~ concerns that contribute to

Comment [zaf9]: Opportunities for preventing suicide exist everyday.

suicide risk such as **relationship problems,** crises, substance use, **poor health,** job/financial problems~~unemployment~~, arguments or conflicts, and **legal problems** can help us identify and support people at risk of suicide. ~~More than half of people who died by suicide did not have a known mental health problem.~~

-
- But, today's report shows that most **states are ~~seeing~~ experiencing increases in suicide rates** and they need to know what can be done to prevent ~~suicides~~them.
- ~~Close coordination of health, law enforcement, business, education, social services, faith, and media sectors is important for preventing suicide.~~ States and communities can take actions now based on the best available evidence.
- States can use *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* to guide actions based on what is known about keeping people safe: **www.cdc.gov/violenceprevention/pub/technical-packages.html**.
- **Preventing suicide involves everyone in the community.** Everyone can learn the signs of suicide, how best to respond, and where to get help.
- I'm going to turn it over now to Dr. Lisa Richardson, who will share the findings in the report.

- **Thank you, Dr. Schuchat.**
- For this Vital Signs report, we analyzed data from the National Vital Statistics System for 50 states and Washington, D.C. We looked at data from the National Violent Death Reporting System or NVDRS, covering 27 states in 2015, and examined circumstances surrounding suicides ~~deaths~~ among people with and without known mental health problems.
- From 1999-2016, suicide rates increased significantly in **44 states**, with **25 states experiencing increases** of **more than 30%**.
- ~~Rates increased significantly among males and females in 34 and 43 states, respectively.~~ Using ~~In~~ 2015 from NVDRS, we found that among suicides in 27

Comment [zaf9]: It's not just about identifying people with these concerns but also taking action to prevent these things.

Comment [zaf9]: This is a little problematic since we aren't saying in 27 states. I don't know that we can generalize. Pretty sure we can't.

Comment [ST(]: I agree and suggest dropping this from Dr. Redfield's script.

Comment [zaf9]: Not sure what this is referring to, the sentence above? If so, it doesn't follow.

Comment [zaf9]: State public health departments can be leaders in bringing together the necessary partners such as…

Comment [zaf9]: Don't think we should just focus on that strategy. We need to highlight a comprehensive approach to SP.

Comment [ST(]: Who is this? Should this be you, Deb?

states, **more than half (54%)** ~~**of deaths in 27**~~ states ~~**did not have**~~ a **known mental health problem**.

Comment [zaf9]: This is a little confusing going from the 34 and 43 to the half of people in 27 states.

- ~~Among people with circumstance information, several circumstances, including~~ ~~r~~**R**elationship **problems/loss** (45.1% vs 39.6%), **life stressors** (54.2% vs 49.7%), and **recent/impending crises** (32.9% vs 26.0%) were **significantly more likely** among ~~those~~ people who died by suicide without a known mental health problem than those~~deaths~~ with mental health problems, but these problems were common across groups.

- **Although these findings are concerning, prevention is possible;** ~~we need~~ comprehensive statewide~~,~~ suicide prevention activities ~~to~~ can address the full range of factors contributing to suicide.

- On a Federal level, the government is tracking the problem to understand trends and groups at greatest risk. They are developing, implementing and evaluating suicide prevention strategies and working with local, state, tribal and other partners to prevent suicide.

- States and communities, can:

    - Identify and support people at risk for suicide.
    - Teach coping and problem-solving skills to help youth and adults manage challenges with relationships, jobs, health, or other concerns.
    - Create safe and supportive environments where people live, learn, work, and play.
    - Make sure people are connected to others in their community and don't feel alone.
    - Make sure those at risk are connected to health systems that include mental and physical healthcare.
    - Strengthen options for temporary assistance for those struggling to make ends meet.
    - Lessen harms and prevent future risk of suicide.

- The bottom line is: it will take a ~~everyone working together~~coordinated and comprehensive approach to prevent suicide.

- Thank you. I'll turn it back to our moderator now.

Moderator: Thank you. (Operator's name), I believe we are ready for questions, please.

[Q&A]

Media Q&A –AFTER FINAL QUESTION- (Moderator): Thank you Drs. Redfield and Schuchat for joining us today, as well as reporters. For follow-up questions, call the press office at 404-639-3286 or send an email to media@cdc.gov. Thank you for joining us; this concludes our call.

How was this research conducted?

Trends in age-adjusted suicide rates among people aged ≥10 years, by state and sex, across six consecutive three-year periods (1999-2016), were assessed using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health problems (MHP).

What are some of the key findings?

Across the study period, suicide rates increased in all states, except Nevada (which had a consistently high rate throughout), with absolute increases ranging from +0.8 (Delaware) to +8.1 (Wyoming) per 100,000. Percentage increases in rates ranged from +5.9% (Delaware) to +57.6% (North Dakota), with increases of more than 30% observed in 25 states.

Trends in state sSuicide rates ~~trends~~ indicated significant increases ~~for~~ in 44 states, for males (34 states) and females (43 states), as well as for the U.S. overall.

While all decedents were predominately male (76.8%) and non-Hispanic white (83.6%), those without known MHP, relative to those with MHP, were more likely male (83.6% vs. 68.8%; odds ratio (OR)=2.3, 95% CI = 2.2-2.5) and racial/ethnic minorities (OR range: 1.2-2.0).

More than half of suicide decedents in NVDRS did *not* have a known mental health problem. This group suffered more from relationship problems and other life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises.

Why did Nevada not see a significant increase in suicide rates?

Nevada had a consistently high rate of suicide throughout the study period. Nevada's suicide rates were not decreasing, but staying relatively the same.

Comment [ST(]: Stopped here.

Comment [zaf9]: I'd put this in the next paragraph. See my comment below.

Comment [zaf9]: Instead of this I'd say ..44 states, with 24 states experiencing increases of more than 30%.

Comment [zaf9]: I wouldn't highlight this. I'd highlight the ages of suicide decedents.

Comment [zaf9]: While Nevada's suicide rate did not increase, it remained consistently high across the study period.

What are some of the limitations to the study?

There are three limitations to the study, first in the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward), or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml).

Third, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often see greater attributions to mental disorders (13), however many methodological variations across studies exist (14). It is likely that some people without known MHP in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known MHP suggests the importance of addressing the broad range of factors that contribute to suicide.

Did the study provide recommendations for prevention?

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. This study identified a need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to behavioral health providers in underserved areas is needed, as is expansion of healthcare systems needed that integrates physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions.

Prevention strategies include:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help youth and adults manage challenges with relationships, jobs, health, or other concerns.
- Create safe and supportive environments where people live, learn, work, and play.
- Make sure people are connected to others in their community and don't feel alone.
- Make sure those at risk are connected to health systems that include mental and physical healthcare.
- Strengthen options for temporary assistance for those struggling to make ends meet.
- Lessen harms and prevent future risk of suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices*, available at: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf to better understand their suicide problem, prioritize evidence-based comprehensive suicide prevention, and save lives.

Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention.

Additional Resources

Comment [zaf9]: Can we go right to the strategies below?

Recommendations for Media Reporting on Suicide, reportingonsuicde.org

If you or someone you know is thinking about suicide or needs support, help is always available. Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or visit http://suicidepreventionlifeline.org

Preventing Suicide: A Technical Package of Policy, Programs, and Practices: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf.

Review Tracker

- NCIPC OC Leslie Dorigo:
- DVP ADS Tom Simon:
- DVP Policy Malia Richmond-Crum:
- DVP SME Deb Stone:
- DVP HCET Marie Ballman: 4/17/2018

Comment [zaf9]: This month's edition presents trends in suicide rates across states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention.

Comment [ST(]: Would like to see a point about the range of other contributing circumstances.

Dear Colleague:

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents our latest findings on suicide trends in the United States. We also highlight strategies for health departments and others working in violence prevention to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Tuesday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in 44 states, with 25 states experiencing increases of more than 30% each.
- More than half of people who died by suicide did not have a known mental health problem

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Web page to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June12, 2016, at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Thank you for your support.

Debra Houry, MD, MPH
Director
National Center for Injury Prevention and Control

James A. Mercy, PhD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control

Review Tracker

- NCIPC OC Leslie Dorigo:
- DVP ADS Tom Simon:
- DVP Policy Malia Richmond-Crum:
- DVP SME Deb Stone:
- DVP HCET Marie Ballman: 4/17/2018

Critical Contacts email

First Name,

I wanted to let you know CDC will be releasing a Vital Signs report today highlighting the state trends in suicide rates from 1999 - 2016. The key findings of the report are:

- There were nearly 45,000 suicides deaths in 2016
- Suicide rates increased by more than 30% in half of US states since 1999
- More than half of people who died by suicide did not have a known mental health problem
- Suicide remains a leading cause of death in the US and is on the rise in 44 states

To reverse this alarming trend, we must continue to coordinate our efforts around prevention. We appreciate Secretary Azar's leadership and the collaboration across HHS and the Federal government to monitor and evaluate this public health problem to understand trends and the groups at greatest risk. We look forward to continuing our work with local, state, tribal, and other partners to prevent suicide. Together we can address the opportunities for prevention every day.

Please feel free to share the information broadly after the embargo lifts at 1 pm, after which the information will be posted at: www.cdc.gov/vitalsigns.

Look forward to speaking with you this afternoon.

[CDC DIRECTOR]

- SAMHSA, Pam Hyde, Pam.Hyde@SAMHSA.hhs.gov
- NIDA, Nora Volkow, nvolkow@nida.nih.gov
- CMS, Andy Slavitt, Andy.Slavitt@cms.hhs.gov
- ONDCP, Michael Botticelli, Michael_P_Botticelli@ondcp.eop.gov
- DEA, Chuck Rosenburg, chuck.rosenberg@usdoj.gov
- HHS, Richard Frank, Richard.Frank@hhs.gov
- NIH, Francis Collins, francis.collins@nih.gov
-IOS

Comment [A]: Can we include something stronger here – an "important" VS or "the first VS on suicide prevention" or something like that.

Comment [A]: These four points are in order from the fact sheet but do we need to keep them in the same order? I'd prefer: bullet point 1 then 4 then 2 then 3. I also don't like 'suicide remains a leading cause of death' since I'm sure many people didn't know it was to start with.

Comment [A]: What about a point about there being other contributing circumstances

Comment [A]: Don't like continue here since I don't think we have been coordinating well enough to start.

Comment [A]: We didn't exactly look at groups at greatest risk we compared people with and without MHP and we looked at common circumstances other than MH.

Comment [A]: Could say the factors that contribute to risk and opportunities for prevention.

I'm surprised not to see mention of the technical package.

Comment [A]: Policy to add the key contacts

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: 6 Aug 2018 11:03:03 -0400
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC);Lane, Gabraelle (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCCDPHP);Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Subject: RE: FW: media inquiry: suicide epidemic

Good morning all!
J. I haven't responded to Zachary with any of this information yet. To all, please let me know your thoughts on the responses and what you would like me to provide him with. It also sounds like his story is pretty much written and this info may or may not be included/attributed, but since he's interested in the issue overall and for future stories, he'd like to have for his own knowledge.
Thanks!
Courtney

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: Sunday, August 5, 2018 2:53 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) ; Lane, Gabraelle (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCCDPHP) ; Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Subject: RE: FW: media inquiry: suicide epidemic

Please do not make these statements attributed to me. While they make good points about how to prevent suicide using the public health approach, the messages are not strongly tailored to how to address 'suicide epidemics (i.e., sudden increases),' which was the focus of Zachary's article. If the preference is to stick with the messaging from the Vital Signs and Technical Package, then please attribute those messages to the authors of those deliverables and feel free to use them and not me for this response. From where I am sitting, I have to respond to Zachary's questions as written and, to me, he is asking questions to improve understanding of how to address 'suicide epidemics' and there are some important nuances in approaches to address suicide epidemics versus using a broader public health approach to preventing suicide across all populations. If not stated delicately, some of our messaging on using the public health approach can contradict what is known about how to address suicide epidemics. If folks think Zachary is just asking about suicide as a public health problem in general, then I agree to proceed with the messages used for the VS and TP. If folks prefer to hold Zachary to a strict interpretation of his questions, then I recommend editing the responses to address epidemics specifically.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Tuesday, July 31, 2018 2:51 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC)

<xkp4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCCDPHP) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: RE: FW: media inquiry: suicide epidemic

Hi all,

I want to make sure that these responses can be sent via email with attribution to J. Looks like that will work for Zachary's story.

Thanks much!

Courtney

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, July 30, 2018 6:44 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: RE: FW: media inquiry: suicide epidemic

Hi Courtney,

I don't know if it's too late but I'm attaching the most updated response inclusive of technical package and vital signs and J's talking points.

Deb

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, July 26, 2018 5:26 PM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: RE: FW: media inquiry: suicide epidemic

Hi all,

Apologies for not circling back on this request sooner, is everyone good with J's talking points?

Thanks!

Courtney

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: Monday, July 16, 2018 3:44 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) ; Lane, Gabraelle (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Subject: RE: FW: media inquiry: suicide epidemic

Hi Courtney et al.,

Sorry for the delay. I drafted some talking points for Zachary Siegel. Please edit as you see fit.

J.

J. Logan, Ph.D.
Suicide and Youth Violence, Emerging Topics (SaYVE) Team
Research & Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
MS: F-63
Email: ffa3@cdc.gov
Telework day: Monday, Wednesday, Friday
Office phone: 770-488-1529
Telework phone: 404-884-4879

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, July 12, 2018 11:30 AM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: RE: FW: media inquiry: suicide epidemic

Thanks so much, J. That's very helpful. Here's more from Zach:

Was hoping for more of a conversation. Generally, I'm interested in discussing:
Ebola and Zika are epidemics where the vectors are known and common/rapid-response solutions like isolation/quarantine, vaccination/inoculation, are largely successful. Today, however, there are epidemics like the opioid epidemic, an epidemic of gun violence, a suicide epidemic, an obesity epidemic, and even more abstract epidemics like loneliness. All of these are, of course, massive public health issues.
Some Qs are:
How do solutions to a suicide epidemic differ from the kinds of medical and technological solutions associated with contagion?
What are the causes/conditions/solutions to more complex epidemics like suicide?
Is the term epidemic used here a mere metaphor? Some have argued the metaphor doesn't quite match the framework of the crisis.

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: Thursday, July 12, 2018 10:51 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
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Subject: RE: FW: media inquiry: suicide epidemic

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J. Logan, Ph.D.
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Centers for Disease Control and Prevention
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Subject: FW: FW: media inquiry: suicide epidemic

Hi All!
I just want to make sure all of us are in the loop with this request. I'll be asking the reporter again for more specific questions before setting up something with J. I did want to bring up the term epidemic, has CDC ever said suicide is an epidemic?
Thanks much!
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Cc: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
Subject: Re: FW: media inquiry: suicide epidemic

My NYT editor asked for a draft by July 30 (with a "sooner the better" caveat). Perhaps scheduling a call early next week would work?
Thanks,
Zach

On Mon, Jul 9, 2018 at 2:55 PM, Zachary Siegel <zasiegel@usc.edu> wrote:

> Thanks, Courtney. Will do.
> On Mon, Jul 9, 2018 at 2:55 PM, Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov> wrote:
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> > Good afternoon,
> > Zachary, please feel free to reach out to me when you have additional information and I can work with J. on setting up something. Will you please send your questions in advance?
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> > **Subject:** RE: FW: media inquiry: suicide epidemic

Sure, sounds good. We also need to coordinate a meeting with our communications liaison. I cc'd her on this email.
J.

From: Zachary Siegel <zasiegel@usc.edu>
Sent: Monday, July 9, 2018 1:51 PM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
Subject: Re: FW: media inquiry: suicide epidemic

Hey, thanks Joseph.
I'd definitely like to chat. I'd like to run a few things by my editor before we chat. So, once I do I'll get back to you and we can put a call on the books. Does that work?
Thanks,
Zach

On Mon, Jul 9, 2018 at 11:24 AM Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov> wrote:

> Hi Zach,
> I received this email from Deb Stone. I do a considerable amount of research on suicide epidemics. If you are interested in that area, I can speak to the topic unless you are specifically interested in Deb's work. If you have any detailed questions, feel free to send them.
> J. Logan
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> **From:** Stone, Deborah (CDC/ONDIEH/NCIPC)
> **Sent:** Monday, July 9, 2018 12:30 PM
> **To:** Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
> **Subject:** FW: media inquiry: suicide epidemic
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> Hi J,
> This seems in your wheelhouse. Would you be able to take this?
> Deb
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> **From:** Zachary Siegel <zasiegel@usc.edu>
> **Sent:** Saturday, July 7, 2018 4:43 PM
> **To:** Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
> **Subject:** media inquiry: suicide epidemic
>
> Hi Deobrah,
> My name's Zachary Siegel and I cover public health and criminal justice for news outlets like Wired, Slate, Vice, New York Magazine, MIT's Undark Magazine, and The Daily Beast, among others. I'm also a Guggenheim Fellow at CUNY's John Jay College of Criminal Justice.
> For a story I'm researching the history of epidemics. There are suicide, overdose, and gun violence epidemics right now in America. These are serious public health crises, but the causes and solutions are much more complicated than vaccination and inoculation, isolation and quarantine, which we commonly associate with epidemics like say, Zika or Ebola.
> I've read a lot of your work on suicide and would like to chat about what an epidemic of suicide really means, and what kind of solutions stem from that definition.
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From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 30 Jul 2018 20:17:18 +0000
To: Crosby, Alexander (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Lenard, Courtney (CDC/ONDIEH/NCIPC);Logan, Joseph (J.) (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
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Subject: RE: FW: media inquiry: suicide epidemic

Since the first question asks about solutions, I think can use the first two paragraphs as Alex suggested and then these two paragraphs below from the technical package talking points. I agree with Alex for Q2. I'll send the full response later today. Have to run now! Thanks!
Deb

Suicide is preventable. Prevention requires understanding and addressing the factors that influence suicide. CDC uses a 4 level model (called the social ecological model) to better understand suicide and what works to help prevent it. This model considers interaction between individual, relationship, community, and societal factors. Just as suicide is not caused by a single factor, research suggests that reductions in suicide will not be prevented by any single strategy or approach. Suicide prevention is best achieved through comprehensive strategies and approaches that target risk and protective factors across individual, relationship, community, and societal-levels and across all sectors, private and public.

CDC has developed a technical package to help states and communities take advantage of the best available evidence to prevent suicide. A technical package is a collection of strategies that represent the best available evidence to prevent or reduce public health problems like violence. They can help improve the health and well-being of communities. This technical package is intended as a resource to guide decision-making in communities and states. CDC expert scientists reviewed the literature and summarized the best-available evidence in the technical package. The technical package highlights seven strategies to prevent suicide: 1) Strengthen economic supports, 2) Strengthen access and delivery of suicide care, 3) Create protective environments, 4) Promote connectedness, 5) Teach coping and problem-solving skills, 6) Identify and support people at risk and 7) Lessen harms and prevent future risk.

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Monday, July 30, 2018 3:35 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
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Subject: RE: FW: media inquiry: suicide epidemic

Greetings:
I think J's response to item #1 is correct however the latter part gets a little too technical. I suggest using just the 1st 2 paragraphs of his response for #1.
On #2, I suggest we use the response from the MMWR vital signs question & answer document.
Why are suicide rates increasing?

While the Vital Statistics data are great for describing trends they don't tell us about the causal factors that are driving the increases.
We do know that suicide is not caused by one factor, but instead, it is typically caused by a combination of individual, relationship, community, and societal factors.
Several such factors could be contributing to the increases:

Economic conditions

The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability could have contributed to increases in suicide risk. Past research on the association between business cycles and U.S. suicide rates indicates that the overall suicide rate rises and falls in connection with the economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.

Opioid epidemic

Increased availability and misuse of prescription opioids may be related to increases in suicide rates. Substance misuse itself is an established risk factor for suicide and, therefore, opioid misuse associated with the opioid overdose epidemic could be driving the suicide rate higher. When we look at who is dying from suicide and who is dying from unintentional overdoses involving opioids, we see that there is overlap in the demographics of the populations most highly affected by suicide and unintended opioid overdose deaths. Data also indicate that opioid prescribing rates are higher in counties where there are higher rates of suicide.

Social media

More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

Rural

While there have been increases and decreases in rates over time, research shows that rates across cities and towns in the United States have been rising, with rural areas experiencing the most increases. The increased rates may be associated with suicide risk factors that are more common in less urban areas, such as limited access to mental healthcare as well as greater social isolation.

Bridge to:

Although the reasons for the increases in suicide rates are not fully understood, we do know a lot about the circumstances that contribute to suicide risk. It is clear that many factors contribute to suicide beyond mental health factors alone.

- These factors include such things as relationship problems (e.g. relationship loss through death, divorce, or break-up; arguments, interpersonal violence), substance use problems, physical health problems, job/financial problems, and legal problems.

Item #3 – the response looks fine. The reporter may ask for some clarification.
Alex C

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Monday, July 30, 2018 10:01 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
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Subject: RE: FW: media inquiry: suicide epidemic

Hi Deb and Alex,
Have you reviewed this already? I'd like your take on the response and I also think it would be good to add some of the points and broader prevention messages from the TP Q&A.

Thank you, Tom

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, July 26, 2018 5:26 PM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
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Subject: RE: FW: media inquiry: suicide epidemic

Hi all,
Apologies for not circling back on this request sooner, is everyone good with J's talking points?
Thanks!
Courtney

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: Monday, July 16, 2018 3:44 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
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Subject: RE: FW: media inquiry: suicide epidemic

Hi Courtney et al.,
Sorry for the delay. I drafted some talking points for Zachary Siegel. Please edit as you see fit.
J.

J. Logan, Ph.D.
Suicide and Youth Violence, Emerging Topics (SaYVE) Team
Research & Evaluation Branch
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Subject: RE: FW: media inquiry: suicide epidemic

Thanks so much, J. That's very helpful. Here's more from Zach:
Was hoping for more of a conversation. Generally, I'm interested in discussing:

Ebola and Zika are epidemics where the vectors are known and common/rapid-response solutions like isolation/quarantine, vaccination/inoculation, are largely successful. Today, however, there are epidemics like the opioid epidemic, an epidemic of gun violence, a suicide epidemic, an obesity epidemic, and even more abstract epidemics like loneliness. All of these are, of course, massive public health issues.
Some Qs are:
How do solutions to a suicide epidemic differ from the kinds of medical and technological solutions associated with contagion?
What are the causes/conditions/solutions to more complex epidemics like suicide?
Is the term epidemic used here a mere metaphor? Some have argued the metaphor doesn't quite match the framework of the crisis.

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J. Logan

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Sent: Monday, July 9, 2018 12:30 PM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
Subject: FW: media inquiry: suicide epidemic

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From: Zachary Siegel <zasiegel@usc.edu>
Sent: Saturday, July 7, 2018 4:43 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: media inquiry: suicide epidemic

Hi Deobrah,

My name's Zachary Siegel and I cover public health and criminal justice for news outlets like Wired, Slate, Vice, New York Magazine, MIT's Undark Magazine, and The Daily Beast, among others. I'm also a Guggenheim Fellow at CUNY's John Jay College of Criminal Justice.

For a story I'm researching the history of epidemics. There are suicide, overdose, and gun violence epidemics right now in America. These are serious public health crises, but the causes and solutions are much more complicated than vaccination and inoculation, isolation and quarantine, which we commonly associate with epidemics like say, Zika or Ebola.

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From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 30 Jul 2018 10:06:12 -0400
To: Lenard, Courtney (CDC/ONDIEH/NCIPC);Logan, Joseph (J.) (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
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Subject: RE: FW: media inquiry: suicide epidemic

I meant Vital Signs and Technical Package Q&A.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Monday, July 30, 2018 10:01 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) ; Lane, Gabraelle (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Subject: RE: FW: media inquiry: suicide epidemic

Hi Deb and Alex,

Have you reviewed this already? I'd like your take on the response and I also think it would be good to add some of the points and broader prevention messages from the TP Q&A.

Thank you, Tom

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, July 26, 2018 5:26 PM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: RE: FW: media inquiry: suicide epidemic

Hi all,

Apologies for not circling back on this request sooner, is everyone good with J's talking points?

Thanks!

Courtney

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: Monday, July 16, 2018 3:44 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R.

(CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: RE: FW: media inquiry: suicide epidemic

Hi Courtney et al.,

Sorry for the delay. I drafted some talking points for Zachary Siegel. Please edit as you see fit.

J.

J. Logan, Ph.D.
Suicide and Youth Violence, Emerging Topics (SaYVE) Team
Research & Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
MS: F-63
Email: ffa3@cdc.gov
Telework day: Monday, Wednesday, Friday
Office phone: 770-488-1529
Telework phone: 404-884-4879

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, July 12, 2018 11:30 AM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: RE: FW: media inquiry: suicide epidemic

Thanks so much, J. That's very helpful. Here's more from Zach:

Was hoping for more of a conversation. Generally, I'm interested in discussing:
Ebola and Zika are epidemics where the vectors are known and common/rapid-response solutions like isolation/quarantine, vaccination/inoculation, are largely successful. Today, however, there are epidemics like the opioid epidemic, an epidemic of gun violence, a suicide epidemic, an obesity epidemic, and even more abstract epidemics like loneliness. All of these are, of course, massive public health issues.
Some Qs are:
How do solutions to a suicide epidemic differ from the kinds of medical and technological solutions associated with contagion?
What are the causes/conditions/solutions to more complex epidemics like suicide?
Is the term epidemic used here a mere metaphor? Some have argued the metaphor doesn't quite match the framework of the crisis.

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: Thursday, July 12, 2018 10:51 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: RE: FW: media inquiry: suicide epidemic

It's more the case that we, CDC, use the term 'epidemic' appropriately, at the appropriate time, and to the right audience. Suicide is not an epidemic but there can be an epidemic of suicide cases, depending

on the population and time period. Normally, we don't use it in media relations because the term could be wildly misused unless we are clarifying its meaning and how it can provide insight and messaging on how to stop the onset of new incidents. Let's see what his questions entail. I can take an initial crack at drafting the talking points and send them to everyone on this email plus REB management.

J.

J. Logan, Ph.D.
Suicide and Youth Violence, Emerging Topics (SaYVE) Team
Research & Evaluation Branch
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Telework phone: 404-884-4879

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, July 11, 2018 4:44 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>
Subject: FW: FW: media inquiry: suicide epidemic

Hi All!

I just want to make sure all of us are in the loop with this request. I'll be asking the reporter again for more specific questions before setting up something with J. I did want to bring up the term epidemic, has CDC ever said suicide is an epidemic?

Thanks much!

Courtney

From: Zachary Siegel <zasiegel@usc.edu>
Sent: Wednesday, July 11, 2018 12:16 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>
Cc: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
Subject: Re: FW: media inquiry: suicide epidemic

My NYT editor asked for a draft by July 30 (with a "sooner the better" caveat). Perhaps scheduling a call early next week would work?

Thanks,

Zach

On Mon, Jul 9, 2018 at 2:55 PM, Zachary Siegel <zasiegel@usc.edu> wrote:

> Thanks, Courtney. Will do.
>
> On Mon, Jul 9, 2018 at 2:55 PM, Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov> wrote:
>
> > Good afternoon,
> >
> > Zachary, please feel free to reach out to me when you have additional information and I can work with J. on setting up something. Will you please send your questions in advance?
> >
> > Thanks much!
> >
> > Courtney

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: Monday, July 9, 2018 3:44 PM
To: Zachary Siegel <zasiegel@usc.edu>
Cc: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>
Subject: RE: FW: media inquiry: suicide epidemic

Sure, sounds good. We also need to coordinate a meeting with our communications liaison. I cc'd her on this email.

J.

From: Zachary Siegel <zasiegel@usc.edu>
Sent: Monday, July 9, 2018 1:51 PM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
Subject: Re: FW: media inquiry: suicide epidemic

Hey, thanks Joseph.

I'd definitely like to chat. I'd like to run a few things by my editor before we chat. So, once I do I'll get back to you and we can put a call on the books. Does that work?

Thanks,

Zach

On Mon, Jul 9, 2018 at 11:24 AM Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov> wrote:

> Hi Zach,
> I received this email from Deb Stone. I do a considerable amount of research on suicide epidemics. If you are interested in that area, I can speak to the topic unless you are specifically interested in Deb's work. If you have any detailed questions, feel free to send them.
> J. Logan
>
> **From:** Stone, Deborah (CDC/ONDIEH/NCIPC)
> **Sent:** Monday, July 9, 2018 12:30 PM
> **To:** Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
> **Subject:** FW: media inquiry: suicide epidemic
>
> Hi J,
> This seems in your wheelhouse. Would you be able to take this?
> Deb
>
> **From:** Zachary Siegel <zasiegel@usc.edu>
> **Sent:** Saturday, July 7, 2018 4:43 PM
> **To:** Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
> **Subject:** media inquiry: suicide epidemic
>
> Hi Deobrah,
> My name's Zachary Siegel and I cover public health and criminal justice for news outlets like Wired, Slate, Vice, New York Magazine, MIT's Undark Magazine, and The Daily Beast, among others. I'm also a Guggenheim Fellow at CUNY's John Jay College of Criminal Justice.
> For a story I'm researching the history of epidemics. There are suicide, overdose, and gun violence epidemics right now in America. These are serious public health crises, but the causes and solutions are much more complicated than vaccination and inoculation, isolation and quarantine, which we commonly associate with epidemics like say, Zika or Ebola.
> I've read a lot of your work on suicide and would like to chat about what an epidemic of suicide really means, and what kind of solutions stem from that definition.

Thank you,
Zach

--
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From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 14 May 2018 22:42:03 -0400
To: Holland, Kristin (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Hold the press--Sorry--big change required
Attachments: QA Document Suicide Vital Signs 5.14.18.docx

Hi Kristin,
You did a fantastic job on this! I have included a few specific edits throughout in the version attached. I'm thinking that we should add something about circumstances to address Anne's point that everyone experiences these.
We added the following to the MMWR: A range of circumstances (relationship problems, life stressors, and recent/impending crises) has been identified as potential risk factors for suicide. Circumstances captured by NVDRS are those identified by next of kin as having actively contributed to a person's suicide. Decedents could have experienced multiple circumstances.
Deb, did you hear back from NVDRS folks about whether this summary is ok?
We need to be careful about not implying that everything we looked at were seen as contributing to the suicide. Mental health and substance use problems did not have to be seen as contributing to be captured in NVDRS. **Deb, I'm wondering if we should change the title of Table 2 in the MMWR to "Conditions and Circumstances preceding suicide…"**
For the q's and a's we could use more of what Katie provided about this issue.
Here is what she wrote
Although we don't have something onhand, here's something to work from as a starting point if it helps: "In NVDRS, precipitating circumstances are stressors or events that were noted by investigators as having contributed to the person's death. In the case of suicide circumstances, many of these are life stressors that are experienced by many people every day, such as job problems, financial problems, and different types of relationship problems. Nevertheless, they give us valuable information about which of these stressors are most central to suicide deaths as we can see which of these, many of which are based on suicide risk factors previously identified in the literature, most commonly are identified as having actively contributed to a person's death by suicide. Many people who die by suicide have several of these circumstances identified in their records and additionally, factors such as resiliency, coping skills, and other protective factors help account for the different ways that people in general think and feel about and react to these types of stressors."
Thank you very much!
-Tom

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 1:22 PM
To: Bruce, Crystal (CDC/OPHPR/OD) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Hold the press--Sorry--big change required
Updated FAQs with "mental health conditions" terminology throughout.
Kristin

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Monday, May 14, 2018 1:11 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>

Cc: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: Hold the press--Sorry--big change required

OK…here you are…thanks!

Crystal

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 12:59 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: Hold the press--Sorry--big change required

How about you send me an email with your revised materials for today and I will forward it (and cc you) to the vital signs team and ask the question about the other materials?

Deb

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Monday, May 14, 2018 12:58 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: Hold the press--Sorry--big change required

Deb…there are some comms products that have cleared the center and the final drafts are with the VS team – dear colleague letter; critical contacts email – how should we handle those?

Crystal

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 12:53 PM
To: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: Hold the press--Sorry--big change required

Ok, we have the go ahead to use mental health condition instead of problem. Please adjust your materials and let me know if you have any questions.

Deb

From: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 11:29 AM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: Hold the press--Sorry--big change required

Samesies.

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Monday, May 14, 2018 11:24 AM

To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: Hold the press--Sorry--big change required

Thanks Deb…Standing by!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 11:23 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: Hold the press--Sorry--big change required
Importance: High

Hi Ladies,

The MMWR editor is requiring that we change the term 'mental health problem' to 'mental health condition.'

I know it's late in the game and very inconvenient but we will likely need to change the terminology in all products.

I say likely because I'm waiting for confirmation from the NVDRS team that this change aligns with the definition in NVDRS.

I expect to hear back shortly so I will let you know the final word but wanted to give you a heads-up.

I know there's a deadline today COB for comm materials. Rich suggested if you need extra time that would be ok given the circumstances.

Sorry again, for all of us.

Deb

Deb Stone, ScD, MSW, MPH
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Suicide, Youth Violence & Elder Maltreatment Team
770.488.3942
dstone3@cdc.gov

CDC's Injury Center
Preventing Injuries and Violence Through Science and Action

Suicide Prevention Vital Signs Q&As

For internal use only.

Comment [ST(]: This is from 2015 and Deb might be updating based on information from Curtis.

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General Background on the Problem of Suicide

- **Suicide is a public health problem.**
  - Nearly 45,000 lives were lost to suicide in 2016, which is approximately one suicide every 12 minutes.
  - Rates have increased by nearly 30% from 19992000-2016 (28.1%)
  - Suicide rates vary by race/ethnicity, age, and other population characteristics, with the highest rates across the lifespan occurring among non-Hispanic American Indian/Alaska Native (AI/AN) and non-Hispanic White population groups, middle-aged adults, veterans and active duty personnel, certain occupational groups, and sexual minority youth.
  - More than half of suicide deaths occur among adults in the prime of their lives, ages 35-64.
  - Suicide rates in rural areas are consistently higher than rates in more urban areas.
  - Suicide and nonfatal self-harm injuries cost more than $69 billion annually in direct medical and work loss costs.
  - Decades of research have shown that suicide is preventable.

- Suicide ranks as the 10th leading cause of death, ~~and has been among the top 12 leading causes of death since 1975 in the U.S.~~
-

What was the impetus for this study?

1. **A CDC employee went missing in February and was later found deceased. Some speculate his death may have been a suicide. Is that why you're publishing this study now?**

   We do not have information to comment on Commander Cunningham's death or whether it was classified as a suicide, however we can say that this study has been in the works for many months now, and analyses for this study began prior to the date when Commander Cunningham disappeared.

   The rising suicide rates in the U.S. have been well documented, and the CDC has a strong portfolio of research describing these trends as well as geographic trends and trends in suicide by age group, sex, and race. **The present study was a logical next step in understanding suicide trends at the state level**, so that many states that have specific suicide prevention efforts in place could better understand and monitor the trends for their state.

2. **Did Commander Tim Cunningham die by suicide?**

   CDC does not have that information. The law enforcement and coroner/medical examiners investigating Dr. Cunningham's case are the ones who make that determination, not CDC. CDC has cooperated with investigating officials to provide information that may be of use for their investigation.

3. **What was the impetus for this study?**

   The CDC has a strong portfolio of research describing the increasing trends in suicide, as well as geographic trends. ~~**and trends in suicide by age group, sex, and race.**~~

   The present study was a logical next step in understanding suicide trends at the state level, so that many states that have specific suicide prevention efforts in place could better understand and monitor the trends for their state.

Is CDC providing funding to states to prevent suicide?

4. **Has CDC provided states resources to prevent suicide? Who in the state does this work?**

   CDC does not provide direct funding to states to conduct suicide prevention work, as CDC has no appropriation for suicide prevention.

Comment [ST(]: I don't think we need this.

Comment [HK(]: Need to confirm whether this is true.

Comment [ST(]: I suggest making this number 1 in this section so this is the first response she sees to this question.

However, states have some mental health resources through SAMHSA and Garrett Lee Smith grant funding.

CDC has created a technical package for suicide prevention that states and communities can use to inform and guide their prevention efforts.

5. What is CDC doing to prevent suicide?

The CDC takes a public health approach to preventing suicide, which involves a number of steps. CDC is:

- Tracking and monitoring data to observe trends and inform policies and programs (for example, NVDRS).
- Identifying risk and protective factors; and developing evidence-based prevention programs.
- Evaluating programs, policies, practices to determine if they prevent risk.
- Sharing information about the best available evidence (for example, the suicide prevention technical package).

Why are suicide rates increasing?

6. Why are suicide rates increasing?

While the Vital Statistics data are great for describing trends they don't tell us about the causal factors that are driving the increases.

We do know that suicide is not caused by one factor, but instead, it is typically caused by a combination of individual, relationship, community, and societal factors.

Several factors could be contributing to the increases:

Economic conditions

The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability could have contributed to increases in suicide risk. Past research on the association between business cycles and U.S. suicide rates indicates that the overall suicide rate rises and falls in connection with the economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.

Opioid epidemic

Increased availability and misuse of prescription opioids may be related to increases in suicide rates. Substance abuse itself is an established risk factor for suicide and, therefore, the epidemic of opioid misuse could be driving the suicide rate higher. When we look at who is dying from suicide and who is dying from overdoses involving opioids, we see that there is overlap in the demographics of the populations most highly affected by suicide and opioid overdose deaths. Data also indicate that opioid prescribing rates are higher in counties where there are higher rates of suicide.

Social media

More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

Rural

While there have been increases and decreases in rates over time, research shows that rates across cities and towns in the United States have been rising, with rural areas experiencing the most increases. The increased rates may be associated with suicide risk factors that are more common in less urban areas, such as limited access to mental healthcare as well as greater social isolation.

Bridge to:

Although the reasons for the increases in suicide rates are not fully understood, we do know a lot about the circumstances that contribute to suicide risk. It is clear that many factors contribute to suicide beyond mental health factors alone.

- These factors include such things as relationship problems (e.g. relationship loss through death, divorce, or break-up; arguments, interpersonal violence), substance use problems, physical health problems, job/financial problems, and legal problems.

7. Why are suicide rates increasing more in less urban (or more rural) areas?

While there have been increases and decreases in rates over time, research shows that rates across cities and towns in the United States have been rising, with rural areas experiencing the most increases.

- **Increased rates may be associated with suicide risk factors that are more common in less urban areas,**
  - Limited access to mental healthcare
  - Greater social isolation.
  - **Loss of jobs, homes, and income associated with the Great Recession as well as the prescription opioid ~~drug~~ epidemic**, which has had a greater impact on less urban areas.
- Urban areas may also experience these risk factors, but to a lesser extent.

8. During the Great Recession, there was an increase in suicide, but why are rates still going up since the economy has bounced back?

Suicide rates have continued to rise after the Great Recession.

Comment [ST(]: Prescription is important because other forms of opioids (heroin) is impacting urban areas.

A previous study found that suicide rates across all urbanization levels in the U.S. increased over the period from 1999-2015, but the gap in rates between less urban and more urban areas widened over this period, and rates in more rural areas increased at a more rapid pace than more urban areas beginning in 2007-2008.

Suicide rates in more rural areas may be driving the increase in suicide rates overall. The rapid acceleration of increasing suicide rates in more rural areas in 2007-2008 may reflect the corresponding start of the Great Recession at about this same time.

- **The disproportionate impact of the recession on rural areas and the longer economic recovery time in these areas may help to explain why suicide rates have remained high overall.**
- Other common suicide risk factors known to be highly prevalent in rural areas, such as mental health and substance abuse problems, potentially influenced by the prescription opioid epidemic impacting such areas over the same time period; poor access to mental healthcare, made worse by shortages in behavioral health care providers in these areas, and greater social isolation may also continue to impact suicide rates in rural areas and overall.

The potential cumulative burden of suicide risk factors in less urban areas may impact not only individuals but relationships, families, and communities as well, suggesting the need for comprehensive suicide prevention measures.

Comment [ST(]: Do we know this? If we are not sure then I would take this out. I'm concerned that this could be used to frame this as only a rural issue and I think it is more widespread than that.

Comment [ST(]: This implies that they are more prevalent in rural areas is that known?

9. Is the opioid epidemic associated with rises in suicide rates?

Both suicide and drug overdoses are on the rise. CDC is actively working to analyze and better understand the trends and risk factors for opioid overdose and suicide, and the connections between the two public health challenges.

Increased availability and misuse of opioids may be related to increases in suicide rates. Substance abuse itself is an established risk factor for suicide and, therefore, the epidemic of opioid abuse could be driving the suicide rate higher. When we look at who is dying from suicide and who is dying from overdoses involving opioids, we see that there is overlap in the demographics of the populations most highly affected by suicide and opioid overdose deaths. Data also indicate that opioid prescribing rates are higher in counties where there are higher rates of suicide.

CDC uses several systems to monitor overdoses, overdose deaths & suicide:

- Deaths – Death certificates, National Violent Death Reporting System (NVDRS) and State Unintentional Drug Overdose Reporting System (SUDORS)
- Nonfatal – National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP), Healthcare Cost and Utilization Project from AHRQ, and emergency department syndromic and EMS surveillance data from CDC's Enhanced State Opioid Overdose Surveillance program

10. Why are suicide rates increasing more among females?

This MMWR showed that suicide rates were increasing for females and males. The increases for females were significant in 43 states and the increases for males were significant in 34 states. It is important to note that while the relative increases in rates were higher for females than for males overall, the absolute suicide rates rose faster for males than females. Male suicide rates are consistently 3 to 5 times

higher than the suicide rates for females. It is important for suicide prevention strategies to address the needs of males and females.

What's going on globally with respect to suicide rates?

11. How does the U.S. compare to other nations with respect to trends in suicide rates?

Globally, suicide rates have been declining.

Global data from the World Health Organization indicates that nearly all European societies experienced rising suicide rates after the Great Recession. However, unlike the U.S., the suicide rate in many European nations stabilized or returned to pre-recession levels after the recession. This may be because the economic recession impacted different countries in different ways, and areas within the U.S. may have taken longer to recover from the recession.

Although suicide rates also increased in Canada during the Great Recession, Canada has experienced a fairly level suicide rate over the past 17 years, with a rate between 12.5 to 13.0 per 100,000.

Unlike in the U.S., ingestion of pesticide is one of the most common methods of suicide globally. Policies related to the sales and import of pesticides, which have reduced access to this lethal means of suicide, have demonstrated impact in preventing suicide in some countries. For instance, in Sri Lanka, the suicide rate decreased from 47 per 100,000 in 1995 to 30.9 per 100,000 in 2005 after the implementation of such policies.

12. What's going on in the U.S. that's not occurring in other countries to explain the increase in suicide rates here?

The U.S. has good surveillance systems in place to track mortality, allowing us to identify the increases in suicide rates and even which areas of the country, age groups, and racial/ethnic groups are most at risk. Unfortunately, these surveillance systems do not assess and track the risk factors that may be contributing to these trends.

We know that ***suicide rates are increasing in most age groups and demographic groups and we are seeing increases across suicide methods***.

The increases in suicide rates are unlikely to be due to any single factor. Factors at the individual, relationship, and community levels - such as age; substance abuse history; school, job, or legal problems; exposure to another person's suicidal behavior; and the accessibility of assistance in the community all contribute to risk.

It is likely that multiple factors are influencing suicide trends. **Some potential contributing factors that people are considering include the following:**

- **The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability**. Past research on the association between business cycles and U.S. suicide indicate that the overall suicide rate rises and falls in connection with the

economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.
    - ***Other developed nations also experienced increased suicide rates during the Great Recession, but for the most part, their suicide rates have leveled off since then.***
- **Increased availability and misuse of prescription opioids.** We know that substance abuse is an important risk factor for suicide. It is unclear to what extent trends in opioid misuse are contributing to suicide rates among adolescents. Adolescents could be at risk due to their own misuse or because of the misuse by family members.
- Another potentially relevant factor is **the role of social media.** More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

Comment [ST(]: I suggest having Malia or Erin take a look at this response if you haven't yet.

Comment [ST(]: This is stronger than what we say in the TP. I think some edits are needed.

Firearms and Suicide

13. Are firearms a major means of suicide globally?

Unlike in the U.S., ingestion of pesticide and hanging are the two most common methods of suicide globally.

Policies related to the sales and import of pesticides, which have reduced access to this lethal means of suicide, have demonstrated impact in preventing suicide in some countries. For instance, in Sri Lanka, the suicide rate decreased from 47 per 100,000 in 1995 to 30.9 per 100,000 in 2005 after the implementation of such policies.

14. How many lives are lost to firearm-related suicides per year?

In 2016, almost 23,000 lives were lost due to suicides by firearm. This equates to 51% of suicides in the US in 2016.

15. Does the CDC want to restrict access to firearms?

The CDC is *not* suggesting that firearms should be taken away from US residents.

Based on prior research, **we know that** safe storage practices can help reduce the risk for suicide by separating vulnerable populations from easy access to lethal means. ~~restricting access to lethal means *among those at risk for suicide* has been proven effective for preventing suicide.~~ This can involve safely storing firearms locked and unloaded, which can help to provide a buffer for those who are thinking about suicide and increases the time it takes them to access lethal means. **We know from prior research that simply providing a buffer in this critical time period can** help reduce risk~~save lives~~**.**

16. What are the leading ways that people die by suicide?

Firearms are the mechanism for about half of all suicides in the United States.

The next leading methods are suffocation and poisoning.

Reducing access to lethal means of suicide among persons at risk for suicide is an intervention with robust supporting evidence; such intervention includes:

- Intervening at suicide hotspots such as bridges
- Counseling around safe storage of medications, firearms, or other household products to keep them away from people at risk ~~or who have made prior suicide attempts~~.
- **These interventions can be combined with other strategies for a comprehensive approach to prevention.**

17. What was the process of obtaining support and resources from the CDC to do this research, given the agency's historical lack of funding for gun violence research?

This study used data from existing public health surveillance systems that collect data on many different causes of injury and death. CDC has and continues to support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impacts of firearm-related injuries ~~violence~~ is an important step toward preventionng ~~firearm injuries and deaths in the United States~~.

18. A previous report shows that a substantial number of gun-caused deaths are suicides. What could drive children to take their own lives and how do they access firearms in the first place?

~~Even though children have much lower suicide rates compared with other age groups, some of the steepest increases from 1999-2014 have been found among children 10-14 years of age.~~

When looking at the circumstances surrounding child firearm suicides, while mental health factors are important, firearm suicides are also frequently related to situational life stressors and relationship problems with an intimate partner, friend, or family member. It is important for parents and other adults who interact with children to be aware that life stressors such as these can have a big impact on children and put them at risk for suicide.

Other researchers have found that safe storage of firearms (storing firearms locked, unloaded, and separate from ammunition) is associated with reductions in adolescent firearm suicide attempts and also unintentional firearm deaths in children.

The Present Study - MMWR Content and Methods

19. How was the current study conducted?

Trends in age-adjusted suicide rates were assessed among people aged ≥10 years, by state and sex, and across six consecutive three-year periods (1999-2016), using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among suicide decedents with and without known mental health conditions.

20. What are some of the key findings?

- Across the study period, **suicide rates increased in all states, except Nevada** (which had a consistently high rate throughout).
    - These increases were statistically significant in 44 states.
    - The percentage increases in rates ranged from 5.9% in Delaware to 57.6% in North Dakota, with increases of more than 30% observed in 25 states.
- Suicide rate trends indicated significant increases for males (34 states) and females (43 states), as well as for the U.S. overall.
- While all decedents were predominately male (76.8%) and non-Hispanic white (83.6%), **those without known mental health conditions, relative to those with mental health conditions, were more likely to:**
    - be male (83.6% vs. 68.8%; odds ratio (OR)=2.3, 95% CI = 2.2-2.5)
    - be racial/ethnic minorities (OR range: 1.2-2.0)
    - to die by firearms (OR=1.6, 95% CI= (1.5-1.7).
- Overall, **the large majority of suicides occurred among people ages of 25-64**.
- **More than half of suicide decedents in NVDRS (27 states) did *not* have a known mental health condition.**
    - This group suffered more from relationship problems and other life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises, however such circumstances were also common in people with mental health conditions.
- **To address the full range of contributing factors to suicide, comprehensive suicide prevention activities are needed.**
    - Such strategies include both upstream prevention to prevent risk from occurring in the first place as well as more downstream activities responsive to the needs of people at increased risk and to prevent re-attempts.
    - The CDC's technical package to prevent suicide provides information about evidence-based strategies, as well as information about the need for a broad, comprehensive approach to preventing suicide.

21. For some states, the reported percentage increase in the suicide rate is quite large. Is this due simply to fluctuations in small numbers of suicides?

The percentages represent increases in rates between the first three-year reporting period (1999-2001) and the last three-year reporting period (2014-2016). By aggregating the data into three-year periods, small suicide counts were avoided. The table below provides the beginning and ending suicide counts and rates for the ten states showing the largest percentage rate increases.

No suicide count appearing in the table below is less than 200, and some counts range into the thousands. Even after recognizing the growth in state populations and any shifts in their age profiles, changes such as those shown would not typically be expected due to random fluctuations alone.

State	Reporting Period	Average Population *	Total Suicides	Annual Rate †	Percentage Increase	Rank
ND	1999-2001	0.56 M	220	13.3	57.6 %	1
	2014-2016	0.65 M	401	20.9		
VT	1999-2001	0.53 M	212	13.2	48.6 %	2
	2014-2016	0.56 M	345	19.7		
NH	1999-2001	1.08 M	435	13.5	48.3 %	3
	2014-2016	1.20 M	719	20.0		
UT	1999-2001	1.84 M	898	17.2	46.5 %	4
	2014-2016	2.48 M	1,809	25.2		
KS	1999-2001	2.31 M	917	13.3	45.0 %	5
	2014-2016	2.51 M	1,446	19.4		
SD	1999-2001	0.65 M	303	15.7	44.5 %	6
	2014-2016	0.74 M	477	22.6		
ID	1999-2001	1.10 M	558	17.3	43.2 %	7
	2014-2016	1.42 M	1,030	24.7		
MN	1999-2001	4.25 M	1,357	10.7	40.6 %	8
	2014-2016	4.77 M	2,161	15.0		
WY	1999-2001	0.43 M	264	20.7	39.0 %	9
	2014-2016	0.51 M	421	28.8		
SC	1999-2001	3.47 M	1,328	12.8	38.3 %	10
	2014-2016	4.29 M	2,310	17.7		

* Average population ≥ 10 years old during reporting period.
† Annual age-adjusted rate per 100,000 population ≥ 10 years old.

22. What is known about which groups are experiencing increases?

The current study found that rates of suicide are increasing, overall, and for males and females. Rates among females increased significantly in 43 states and rates among males increased significantly in 34 states.

- In general, suicide rates in the U.S. have increased by nearly 30% since 1999.
    i. Increases were observed for both women and men in all age groups under 75.
- Certain groups have had particularly high greatest increases since 1999, including:
    i. Working-age adults 35-64 yrs, ~~young people aged 10-14, particularly females~~
    ii. Non-Hispanic whites, and non-Hispanic American Indians / Alaska Natives and
    iii. People living in rural areas.
    iv. Rates have increased for males and female however the rate for males is consistently 3-5 times higher than the rate for females

23. How do people with and without mental health conditions differ with respect to suicide?

People with and without mental health conditions had similarities and differences

- While all decedents were predominately male (76.8%) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely male (83.6% vs. 68.8%;) and racial/ethnic minorities (OR range: 1.2-2.0).
- Suicide decedents without known mental health conditions also had significantly greater odds of perpetrating homicide-suicide (adjusted odds ratio aOR = 2.9, 95% CI = 2.2-3.8). Although this represents a small percentage of suicides in both groups.
- While firearms were the most common method of suicide used overall (48.5%) and for both groups, decedents without known mental health conditions were more likely to die by firearm (55.3% vs. 40.6%) and less likely to die by hanging/strangulation/suffocation (26.9% vs 31.3%) or poisoning (10.4% vs 19.8%) than those with known mental health conditions. (These differences remained significant in the adjusted models).
- Among decedents with toxicology results, decedents without known mental health conditions were less likely to test positive for any substance overall (aOR=0.8, 95% CI=0.7-0.8), such as opioids (aOR=.90 95% CI=0.81-.99) but more likely to test positive for alcohol (aOR=1.2, 95% CI=1.1-1.3).
- People without known mental health conditions were less likely to have substance abuse problems (aOR=0.7, 95% CI=0.7-0.8).
- Two-thirds of those with known mental health conditions had a history of mental health or substance abuse treatment (67.2%) and just over half (54.0%) were in current treatment.
- Decedents without, versus those with, known mental health conditions, had significantly greater likelihood of any relationship problem/loss (45.1% vs. 39.6%), specifically intimate partner problems (30.2% vs. 24.1%), arguments/conflicts (17.5% vs. 13.6%), and recently perpetrating interpersonal violence (3.0% vs. 1.4%). They also were more likely to have experienced any life stressors (54.2% vs 49.7%), such as criminal-legal problems (10.7% vs. 6.2%), or eviction/loss of home (4.3% vs. 3.4%) and were more likely to have had a crisis within the preceding or upcoming two weeks (32.9% vs. 26.0%). All of these differences remained significant in the adjusted models.
- Among all people with crises, intimate partner problems were the most common types and did not differ by mental health group status.
- Physical health problems (23.2% and 21.4%) and job/financial problems (15.6% and 16.8%) were commonly experienced by both groups (with and without mental health conditions, respectively)
- Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR=0.5, 95% CI=0.4-0.5), but among those who were recently released (5.1%), they were significantly more likely to be released from a correctional facility (25.7% vs. 8.7%), hospital (43.7% vs. 33.0%), or other facility (e.g., alcohol/substance treatment) (aOR=2.5 95% CI=1.8-3.3), than those with a known mental health conditions. Among decedents with known mental health conditions who were recently released from an institution (10.2%), 46.7% of this group were released from psychiatric facilities.
- Decedents without known mental health conditions, compared to those with mental health conditions, were significantly less likely to have a history of suicidal ideation (23.0% vs. 40.8%) and prior suicide attempts (10.3% vs. 29.4%). More than one in five people in both groups disclosed suicide intent (22.4% vs. 24.5%).

24. Why did Nevada not see an increase in suicide rates?

While Nevada's suicide rate did not increase, it remained consistently high across the study period.

25. Why did this study focus on those aged 10 and older?

Suicide rates were analyzed for people aged ≥10 years only, because determining suicidal intent in younger children can be difficult.

a. Suicide is defined as self-directed injurious behavior with an intent to die as a result of the behavior, and youth under the age of 10 may not fully understand the implications of their actions. (CDC web site)

26. How was "crisis" defined in this study?

For this study, a "crisis" was a current/acute event that occurred within the 2 weeks of a suicide. Crises are indicated in an NVDRS source report to have contributed to the suicide. A crisis can precede the death (e.g., had a bad argument the day before the incident, divorce papers served that day, or victim laid off the week before) or be an impending event (e.g., house was to be foreclosed on the day after the incident or court date for a criminal offense three days after the suicide). Crises are interpreted from the eyes of the victim. This is particularly relevant for young victims whose crises, such as a bad grade or a dispute with parents over a curfew, may appear to others as relatively minor.

27. How did you define a mental health condition?

The National Violent Death Reporting System (NVDRS) defines a mental health condition as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (9), with the exception of alcohol and other substance use disorders, which are captured separately in the system.

a. Data on mental health conditions are abstracted from the investigative reports included within NVDRS and that are associated with each suicide.
b. Investigative reports are those filed by law enforcement and coroners/medical examiners.
c. Information obtained from these reports is dependent upon the extent of informant knowledge that may impact data completeness and accuracy.

28. Are the people without mental health conditions just people who haven't been diagnosed with a mental health conditions?

It is possible that the people without mental health conditions in this study had a diagnosable mental health conditions but had not been diagnosed, or that their mental health conditions was unknown to informants who provided circumstantial information to law enforcement. Studies including more in-depth interviews with next-of-kin often cite greater attributions to mental disorders, however many methodological variations across studies exist. It is likely that some people without known mental health conditions in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

29. Are suicides by people without mental health conditions considered impulsive?

Suicide decedents who do not have mental health conditions should not necessarily be considered impulsive.

- As this study demonstrates, there are many reasons, beyond mental health conditions alone, why people take their own lives.

- 54% of the study sample did not have a known mental health condition, but people in this group still experienced challenges in their lives that contributed to their suicide.
- They may have been experiencing these challenges for an extended period of time and may have had suicidal thoughts leading up to their suicide, which may indicate that the suicide was not impulsive
    - 35% of those without mental health conditions left a suicide note
    - 23% were known to have a history of suicidal ideation
    - 22% had disclosed suicidal intent to another person
    - 10% had previously attempted suicide

30. How many suicides are considered impulsive?

- *A **previous case-control study of survivors of nearly lethal suicide attempts*** indicates that about 24% of this group acted impulsively on their suicidal thoughts
    - i.e., less than 5 minutes passed between their initial thought of suicide and their nearly lethal suicide attempt
    - **76% of attempt survivors did not meet this definition of impulsivity with respect to their suicide attempt.**

31. Why does this study find such a low rate of mental health conditions compared to psych autopsy studies?

Psychological autopsy studies that utilize in-depth interviewing of surviving friends/family and often include record review typically show that a larger proportion of suicide decedents have a mental health diagnosis. However, variations in the methodology of psychological autopsy studies and the current study may impact the prevalence of mental health conditions identified. It is likely that some people without known mental health conditions in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

32. Why did you only look at suicide circumstances in 27 states?

a. In 2015, the National Violent Death Reporting System collected data from 27 states. The data collected from these states were used for the analysis. More current data is not yet available.
b. In 2016, NVDRS collected data from 40 states, D.C. and Puerto Rico however data are not yet available.
c. The FY 2018 omnibus appropriation bill provided funding and Congressional direction to expand the NVDRS program to all 50 states and the District of Columbia. CDC is actively working toward that goal.

33. What are some of the limitations to this study?

There are three limitations to the study:

- First, **in the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent (potentially biasing**

reported suicide rates downward), or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward).

- Second, **NVDRS is not yet nationally representative**; the 27 states included in this study represent 49.6% of the U.S. population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml).
- Third, **abstractors of NVDRS data are limited to information contained in investigative reports.** Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often cite greater attributions to mental disorders, however many methodological variations across studies exist. It is likely that some people without known mental health conditions in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.
- **We know that suicides are underreported.** It is possible that some suicides were coded as unintentional or deaths of undetermined intent. It is unclear how that could impact estimates of trends or conclusions about circumstances.

The National Violent Death Reporting System

34. What is the National Violent Death Reporting System?

- The **National Violent Death Reporting System (NVDRS) is a data system that provides states and communities with a clearer understanding of violent deaths.** NVDRS data can be used to guide local decisions about efforts to prevent violence and track progress over time. NVDRS is the only state-based surveillance (reporting) system that pools data on violent deaths from multiple sources into a usable, anonymous database. These sources include state and local medical examiner, coroner, law enforcement, toxicology, and vital statistics records. Pooling these data can provide CDC with a detailed, comprehensive picture of how and why violent deaths occur.
- **NVDRS includes over 600 unique data elements that provide valuable context about violent deaths such as**
  - Relationship problems; mental health conditions and treatment; toxicology results; and life stressors
    - Including recent problems with a job, finances, or physical health problems.
  - Extensive information about the incidents, such as weapons used, characteristics of suspects, and locations where they occurred are included. Such data are far more comprehensive than what is available elsewhere.
- **NVDRS can help identify populations particularly affected by fatal violence**. The system not only provides details on specific manner of violent death, but also identifies common factors that span multiple types of violence.
- The NVDRS FAQ page has more details: https://www.cdc.gov/violenceprevention/nvdrs/faqs.html

35. How does using the National Violent Death Reporting System help to make the statistics more complete?

Although limited to the 27 states participating in NVDRS during the time period of the study, **data from NVDRS provide the only detailed information available on the circumstances surrounding these**

deaths, therefore taking the findings beyond reporting numbers and rates and providing unique information on the context in which people die from suicide.

36. Is the National Violent Death Reporting System expanding to 50 states?

We are happy to announce that **beginning in FY18, we are able to make funding available to all 50 states for the implementation of the NVDRS.**

Currently, 40 states, Washington, DC and Puerto Rico are funded by NVDRS.

Expanding NVDRS to 50 states allows us to meet one of the national goals ~~we~~ set forth for Healthy People 2020 (IVP-43).

Comment [ST(]: I think this is sufficient.

Comment [HK(]: Should we add anything else re: HP2020?

Warning signs of suicide and what to do if you know someone at risk

37. A lot of the problems mentioned as contributing to suicide in this study seem very common, how can someone tell who's at risk?

Many people think that suicide is an inexplicable act, when, in reality, many known risk factors exist.

These include:

- History of previous suicide attempts
- Family history of suicide
- History of child maltreatment
- History of depression or other mental illness
- Alcohol or drug abuse
- Feelings of hopelessness or isolation
- Impulsive or aggressive tendencies
- Stressful life event or loss
- Easy access to lethal methods
- Exposure to the suicidal behavior of others
- Isolation, lack of social connectedness

Researchers agree that suicidal behavior results from an interaction of factors and is rarely due to a single cause.

38. What are the warning signs for suicide?

The warning signs for suicide are:

- Expressing hopelessness
- Increased anger or rage
- Extreme mood swings
- Sleeping too little or too much
- Making plans for suicide
- Talking and/or posting about suicide
- Feeling unbearable pain
- Increased anxiety
- Securing lethal means
- Increased substance use
- Feeling like a burden

- Isolation

39. What should someone do if they believe someone may be suicidal?

- **Ask** the question, "Are you thinking about suicide?" Asking the question won't make someone suicidal, and instead, may relieve or reduce the feeling.
- If the person says yes, **keep** them safe. Find out if they have a suicide plan. Remove any lethal means in the environment, if possible, and do not leave the person alone.
- **Be there** and show concern. Don't act surprised or dismiss their feelings. Take the person seriously, and do not assume they are joking.
- **Help them connect** to resources, for example, by calling the National Suicide Prevention Lifeline (1-800-273-TALK (8255)) or by connecting the person to someone in the community who can help, e.g. emergency department, counselor, pastor.
- **Follow up** - After the person is safe, follow up in the days ahead with a phone call, ask them how they are doing. See if there is anything else that you can do.

Comment [ST(]: It might be good to add that you can learn more about these steps to help by going to http://www.bethe1to.com/

40. Where can people go for help?

No matter what problems people deal with, we want to help them find a reason to keep living. By calling 1-800-273-TALK (8255) people will be connected to a skilled, trained counselor at a crisis center in their area, anytime 24/7. There are many success stories where people in need have reached out to others or family or friends have intervened to get people help. They got the support or treatment they needed and were able to get through a crisis.

Suicide among Veterans

41. Do you have any information on suicide among Veterans and Military service members?

While we did not describe Veteran suicides in this study, here are some key epidemiologic findings from other reports published by the Departments of Veterans Affairs and Defense, as well as the CDC .

CDC and its partners are currently doing more research to understand the extent to which the general rise in suicide rates can be attributed to the rise in suicide rates among Veterans.

Veterans:

- **Veterans accounted for 18 percent of adult suicides but constituted only 8.5 percent of the U.S. adult population (ages 18+).**

- An average of **20 Veterans died by suicide each day**; roughly **14 of these are not using VHA services**.
- The overall **burden of Veteran suicide is mostly among Veterans of middle to older adult ages**.
    - An estimated 65% of Veteran suicides occurred among Veterans ages 50 years an older

- **Rates dramatically increased from 12/100,000 in 2005 to 110/100,000 in 2014** among young Veterans aged 18-24 years who were using VHA services and were in Operations Enduring Freedom, Iraqi Freedom, or New dawn
- Suicides among young Veterans aged 18-35 years are highly concentrated in a small proportion of counties.
    - Within 17 NVDRS states, an estimated 33% of suicides among Veterans aged 18-35 years occurred in just 3% of U.S. counties and 69% occurred in 13% of U.S. counties. Many of these high burden counties do not have easy access to VHA facilities.
- Accounting for age and sex, risk for suicide was 21 percent higher among Veterans versus civilians.
- Accounting for age, risk for suicide was 2.4 times higher among female Veterans versus female civilians

Active duty:

- Suicide rates have doubled from 12.5 per 100,000 in 2005 to 30 deaths per 100,000 in 2012. Steady declines in recent years have been observed (although this could be because more service members were recently discharged and therefore their suicides would be reflected in the Veteran population)
- Since 2001-2014, 51% of suicide decedents were Army service members; 18% were Air Force service members; 17% were Navy service members; 14% were Marines
- Key epidemiological findings include:
    - 94% were male
    - 72% were of white race
    - 87% were of non-Hispanic ethnicity
    - 83% were under the age of 35 years
    - 88% were in the enlisted ranks of E1-E9
    - 72% only had a high school graduate level of education (or less)
    - 52% were married
    - 68% of suicides were the result of firearm injuries
    - 54% had a history of deployment

42. Do you think the rate increases in suicide across the U.S. is the result of increases in Veteran suicides?

For this study, we were unable to explore the reasons why we observed these state increases. Therefore, we are unable to determine the extent to which ~~if~~ the broad increase in suicide rates across the states is the result of increases in the Veteran suicide rate. This question needs further exploration.

43. Is CDC engaged in preventing suicides among Military service members and Veterans?

CDC has partnered with the Departments of Veterans Affairs and Defense on numerous innovative suicide prevention projects to help address and prevent suicide among active duty service members and Veterans.

- The innovations span across public health service. Such efforts are focused to:

- Improve surveillance of suicide
- Increase understanding of the antecedents of suicide and potential factors that might protect against risk of suicide
- Improve early identification of suicide risk and rapid response to those in need of services, and evaluate key population-level suicide prevention policies and strategies being implemented across states and at military installations.

The overall portfolio of work embraces the seven key approaches to prevent suicide as outlined in the CDC's technical package.

Comment [ST(]: Not sure what this really means.

Opioids and Suicide

44. How are suicide, opioid misuse, and Adverse Childhood Experiences related?

We know that adults who experienced Adverse Childhood Experiences, or ACEs, are at risk for both suicide and substance abuse. Additionally, it is important to note that children whose parents are dealing with substance abuse or have overdosed are experiencing ACEs, as are children whose parents attempt or die from ~~complete~~ suicide. So addressing trauma and preventing ACEs can be important to prevention of suicide and opioid misuse as well.

45. Why are opioid overdoses increasing?

Drug overdoses killed 63,632 Americans in 2016. Opioids—prescription and illicit—are the main driver of drug overdose deaths. Nearly two-thirds of these deaths (66%) involved a prescription or illicit opioid. Overdose deaths increased in all categories of drugs examined for men and women, people ages 15 and older, all races and ethnicities, and across all levels of urbanization.

The rise in opioid overdose deaths can be outlined in three distinct waves:

- The first wave began with increased prescribing of opioids in the 1990s , with overdose deaths involving prescription opioids (natural and semi-synthetic opioids and methadone) increasing since at least 1999.
- The second wave began in 2010, with rapid increases in overdose deaths involving heroin.
- The third wave began in 2013, with significant increases in overdose deaths involving synthetic opioids – particularly those involving illicitly-manufactured fentanyl (IMF). The IMF market continues to change, and IMF can be found in combination with heroin, counterfeit pills, and cocaine.
- Recent CDC data (Seth P, Scholl L, Rudd RA, Bacon S. Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants — United States, 2015–2016. MMWR Morb Mortal Wkly Rep. ePub: 29 March 2018.) confirms that increases in drug overdose deaths are being driven by continued sharp increases in deaths involving synthetic opioids other than methadone, such as illicitly manufactured fentanyl (IMF).

46. Does prescribing opioids to patients with chronic health conditions increase suicide risk?

Research has shown that chronic health conditions, including painful conditions such as arthritis, migraines, and fibromyalsia, are associated with increased suicide risk. Further, patients receiving opioid therapy for chronic pain are at elevated risk for mental health conditions and suicide attempts. This may reflect an increased likelihood of prescribing opioids by providers to patients with risk factors for

suicide, including mental health conditions, chronic pain, and opioid use disorder. Increased opioid availability can also offer greater access to lethal means for suicide.

47. Can the increase in suicides among certain populations be attributed to opioid use, or to chronic pain?

A recent study showed that chronic health conditions are associated with increased suicide risk, particularly when multiple chronic conditions are present (Ahmedani et al., 2017). Opioids can be prescribed for chronic conditions, and patients receiving opioid therapy are at elevated risk of attempting suicide. However, suicide risk might be able to be reduced by improving pain management consistent with prescribing guidelines. For example, in a study of veterans on long-term opioid therapy, approximately 1-2% of patients attempted suicide within 6 months of receiving a prescription. The VA facility engaged in an effort to increase compliance with prescribing guidelines by making more consistent use of drug screening, providing follow-up within 4 weeks for patients initiating new opioid prescriptions, and avoiding co-prescribing of sedatives with opioids. The study found that by providing follow-up as recommended in the guideline, the risk of suicide could be reduced by 5 times (Im et al., 2015). In a second study, researchers found that compliance with the VA/Department of Defense (DOD) guideline improved patient safety for VA opioid-prescribed patients (Brennan et al 2016). For example, urine drug screening increased significantly, and this was associated with lower risk of suicide among patients.

48. Has the CDC's Guideline for Prescribing Opioids caused people suffering in pain to contemplate or die by suicide?

Chronic pain can result in considerable suffering. Having a chronic pain condition, compared to no physical pain, is associated with a higher likelihood of suicide, suicidal ideation and suicide attempts, and in many cases this association persists even after controlling for co-morbid mental health and/or substance abuse disorders. This is the finding of a recent meta-analysis of 30 studies that examined the association of physical pain with a range of suicide related outcomes among people with and without pain conditions. (Ref: Calati, R., Artero, S., Courtet, P., & Lopez-Castroman, J. (2016). Framing the impact of physical pain on suicide attempts. A reply to Stubbs. J Psychiatr Res, 72, 102-103. doi:10.1016/j.jpsychires.2015.10.018)

- **Among patients taking opioids, a recent study suggests that the most important factor that predicts transition from suicidal ideation to suicidal attempt is the belief that pain can't be successfully managed (i.e. hopelessness about pain management), rather than factors such as condition or pain severity.**
- A recent study of US veterans prescribed opioid medications for chronic pain management revealed that a very small percent attempted suicide (less than 2%), and that having a mood disorder increased the risk for suicide attempt. Importantly, use of guideline-recommended practices, including use of urine drug testing, greater-follow-up, and lower co-prescription of sedatives was associated with a lower risk of suicide attempts.

Additional research would tell us more about the associations among chronic pain, opioid use, and suicide, and inform prevention efforts. The available evidence highlights the importance of urine drug testing and avoiding co-prescribing of benzodiazepines, whenever possible, and providers remaining alert to signs of anxiety and depression, using validated instruments to assess for mental health

conditions, re-evaluating patients with depression or mental health conditions more frequently than every 3 months, considering use of tricyclic or SNRI antidepressants for analgesic as well as antidepressant effects, and considering behavioral health specialist consultation for any patient with a history of suicide attempt or mental health disorder, as recommended in the CDC Guideline.

49. Why doesn't CDC think chronic pain is important? Why is the prescription drug overdose epidemic the focus?

Chronic pain is a public health concern in the United States. Patients with chronic pain deserve safe and effective pain management.

- Opioids can help manage some types of pain but also have serious risks of addiction and overdose.
- While evidence supports short-term effectiveness of opioids, there is insufficient evidence that opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.
- Primary care providers are concerned about opioid pain medication misuse, are worried about patient addiction, and want more training in prescribing opioids.

CDC's role is to tackle the biggest health problems causing death and disability for Americans, putting science and advanced technology into action to prevent disease and promote healthy and safe behaviors, communities and environment.

CDC recently played a leading role in getting public health goals pertaining to chronic pain included in Healthy People 2020, and facilitated the inclusion of questions about chronic pain in the 2016-17 National Health Interview Survey.

CDC scientific experts also provided review and input regarding the overall National Pain Strategy (NPS) led by HHS. The NPS outlines a coordinated plan for reducing the burden of chronic pain on the American public. It includes key recommendations in areas including population research, prevention and care, disparities, service delivery and payment, professional education and training, and public education and training. The strategy calls for:

- "Developing methods and metrics to monitor and improve the prevention and management of pain.
- Supporting the development of a system of patient-centered integrated pain management practices based on a biopsychosocial model of care that enables providers and patients to access the full spectrum of pain treatment options.
- Taking steps to reduce barriers to pain care and improve the quality of pain care for vulnerable, stigmatized and underserved populations.
- Increasing public awareness of pain, increasing patient knowledge of treatment options and risks, and helping to develop a better informed health care workforce with regard to pain management."

Drug overdose one of the few problems getting worse in US – affecting all ages, races, communities. The opioid overdose crisis is being fueled by both prescription opioids and illicit drugs, like heroin and illicitly-manufactured fentanyl. CDC plays an important role in understanding and addressing the causes of the opioid overdose epidemic.

- Opioids (including prescription opioids, heroin, and fentanyl) killed more than 42,000 people in 2016, more than any year on record.

- 40% of all opioid overdose deaths involve a prescription opioid.
- The best ways to prevent opioid overdose deaths are to improve opioid prescribing, reduce exposure to opioids, prevent misuse, and treat opioid use disorder.

Managing chronic pain is important to the health and well-being of all Americans, and preventing, assessing, and treating chronic pain can be a challenge. Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs. The CDC guideline provides recommendations to help determine when to initiative and continue opioid prescribing for pain outside of active cancer treatment, palliative care, and end-of-life care to ensure patients have access to safe and effective chronic pain treatment. CDC aims to save lives and prevent prescription opioid overdoses by equipping providers with the knowledge, tools, and guidance they need.

Suicide Prevention

50. Did the study provide recommendations for prevention?

Comprehensive suicide prevention activities both upstream (before suicide risk begins) and downstream (after people have been identified as at-risk, or have attempted suicide) are needed to address the full range of factors contributing to suicide.

- For example, among people with mental health conditions, the study identified a need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to providers in underserved areas is needed, as is expansion of healthcare systems that integrate physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions.
- In addition to strategies addressing mental health conditions, the study identified the need for attention to the broader range of circumstances contributing to suicide, including relationship, substance use, physical health, job, financial, and legal problems.

Taken, together a comprehensive approach to suicide includes the following strategies:

- Identifying and supporting people at risk of suicide.
- Teaching coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments, including safely storing medications and firearms to reduce access among people at risk.
- Connecting people to others in their community so they don't feel alone.
- Connecting people at risk to effective and coordinated mental and physical healthcare.
- Expanding options for temporary assistance for those struggling to make ends meet.
- Preventing future risk of suicide among those who have lost a loved one to suicide

Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices*, available at: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf to better understand their suicide problem, prioritize evidence-based comprehensive suicide prevention, and save lives.

51. What can be done to prevent suicide?

Suicide is preventable.

CDC released a technical package of policies, programs, and practices to prevent suicide to help communities focus on a core set of strategies that have the best available evidence and greatest prevention potential.

The technical includes examples of programs that local implementers might tailor to fit the needs of their community. The technical package **includes 7 strategies designed to work together to achieve the greatest impact possible**.

i. Strengthen economic supports
ii. Strengthen access and delivery of suicide care
iii. Create protective environments
iv. Promote connectedness
v. Teach coping and problem-solving skills
vi. Identify and support people at risk
vii. Lessen harms and prevent future risk

For example, an evidenced based suicide prevention program called Sources of Strength was developed with rural and tribal communities in North Dakota to promote connectedness between youth and caring adults. The program works to understand and respond to underlying causes of suicidal behavior and promote protective factors against suicidal behavior before the causes result in adverse outcomes.

Other innovative prevention strategies, such as telebehavioral health (telephone, video and web-based technologies), are a promising option to increase access to health care and mental health care in rural communities. However, rural communities often have limited access to the internet suggesting a need to increase broadband access and to identify other ways to deliver promising prevention supports.

Everyone can play a role in suicide prevention.

- Physicians have an important role to play in recognizing and appropriately treating mental health conditions.
- Other professionals who work with vulnerable populations (e.g. parole officers, teachers, etc.) play an important role in identifying and referring at-risk individuals.
- Employers can play a role too.
    - EAP programs can work to reduce stigma about seeking help and improving access to care.

There are also ~~guidelines~~ recommendations for the media regarding how to report on suicide to raise awareness without increasing the risk of additional suicides among vulnerable populations. We know that risk can increase when the media provides details about the methods used, dramatic/graphic headlines, or glamorize a death (see http://reportingonsuicide.org/recommendations/).

52. What is a technical package?

- A technical package is **a collection of strategies that represent the best available evidence to prevent or reduce public health problems like violence**. They can help improve the health and well-being of communities.

CDC's suicide prevention technical package is intended as a resource to guide decision-making in communities and states.

Comment [ST(]: We need to be sure to use "recommendations" rather than "guidelines". This was a deliberate decision in how the document was titled.

- CDC expert scientists reviewed the literature and summarized the best-available evidence in the technical package. The package has been reviewed by grantees/funded partners, federal partners, and other audiences.
- The technical package highlights seven strategies to prevent suicide.
- This technical package ~~includes~~ describes programs, practices, and policies along with the evidence of their impact on suicide or risk and protective factors for suicide.
- The strategies are presented in order from those with the greatest potential to produce broad public health impact on suicide followed by those with potential to impact subsets of the population (e.g., persons who have already made a suicide attempt).

53. If suicide rates are increasing, does that mean the evidenced-based strategies that have been identified are not working?

The evidence tells us that there are strategies that work.

- These strategies and approaches do not work if they aren't properly implemented or expanded to reach larger audiences.
- There are many reasons why effective programs are not implemented and expanded, but a lack of funding for suicide prevention has been identified as a contributing factor.

The most effective strategies are comprehensive and use a public health approach as opposed to focusing exclusively on ~~just a~~ mental health conditions~~approach~~, to impact a broader audience. There is also the issue of stigma around suicide and mental health care, which discourages people at risk for self-harm from seeking help. Suicide is preventable, but we need sufficient investment and a comprehensive public health approach.

54. Where can people go to get more information about suicide prevention?

Visit the CDC Injury Center website at https://www.cdc.gov/violenceprevention/suicide/

55. What partnerships or sectors should be involved in suicide prevention?

- Public health agencies can play an important role in preventing suicide. They can provide leadership and bring critical resources to address the problem. However, the strategies and approaches outlined in CDC's technical package cannot be accomplished by the public health sector alone and require a collective effort across sectors.
- Other sectors vital to prevention efforts include:
  - Education
  - Government (local, state, and federal)
  - Social services
  - Health services
  - Business
  - Labor
  - Justice
  - Housing
  - Media
  - Community organizations (e.g., foundations or faith-based and other organizations)
- Each sector has an important role:
  - Local and state public health agencies and organizations can work to convene partners, lead efforts, track progress, and help evaluate efforts.

- Education and the public health sector are vital to supporting the development, evaluation, and adoption of effective programs that promote connectedness or that teach coping and problem-solving skills.
- Business, workplaces, housing, and local and state government entities are in a position to help implement policies and programs that directly address some of the underlying risks and environments that increase the risk for suicide.
- The healthcare, public health, justice, and social service sectors can work together to identify and support people at-risk of suicide and their families.
- Across all strategies – community organizations and other non-governmental organizations are vital to prevention.

56. Is it necessary to monitor and evaluate prevention efforts?

- It is important to have data to monitor the extent of the problem so you can see if your prevention efforts are producing the desired impact.
- There are existing data sources for you to consider such as CDC's National Vital Statistics System (NVSS), the National Violent Death Reporting System (NVDRS), the National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP), the Youth Risk Behavior Surveillance System (YRBSS), and the National Survey on Drug Use and Health (NSDUH).
  - If gaps in the data exist, you may want to look for data collected at the local level. YRBSS provides some local data. You may also want to consider data from state and local Child Death Review teams and Suicide Death Review Teams (where available).
- The data you collect can be used to identify and address gaps in surveillance systems as well as plan programs and evaluate the impact of your efforts.

Talking about suicide & suicide contagion

57. Will talking about suicide give people the idea to do it? Could we do more harm than good?

Talking about suicide does not cause suicide to occur.

- In fact, **it can be an excellent prevention tool.**
  - Talking breaks the secrecy that surrounds suicidal behavior and lets people know that help is available.
- **By not talking about suicide, we increase the isolation and despair of individuals thinking about it and perpetuate the stigma associated with suicidal ideation and behavior.**

58. What is meant by "suicide contagion" or "copy-cat" suicide?

These words describe a process by which exposure to suicide or suicidal behavior of one or more persons influences similar behavior by vulnerable individuals. Research has shown that graphic, sensationalized or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion.

59. Do media reports regarding suicide increase the number of copy-cat suicides? What suggestions does CDC have for news media covering suicide issues in their community?

CDC research suggests that stories about suicide can help inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. They can

also highlight opportunities to prevent suicide. Media stories about individual deaths by suicide may be newsworthy, but they also have the potential to do harm. Implementation of recommendations for media coverage of suicide has been shown to decrease suicide rates. For more information about these recommendations and tips for covering suicide visit Reporting on Suicide: Recommendations for the Media: https://www.afsp.org/news-events/for-the-media/reporting-on-suicide

60. What suicide story angles should reporters consider?

- Trends in suicide rates accompanied by prevention strategies
- Recent advances in prevention strategies
- Individual stories of how prevention was life-saving
- Stories of people who overcame desperate circumstances without attempting suicide
- Myths about suicide
- Warning signs of suicide
- Actions that individuals or families can take to prevent suicide by others
- Actions that communities can take to support connections among people that help to reduce risk

What role do the economy and social media play in increasing suicide rates?

61. What role does the economy play in increasing suicide rates?

The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability could have contributed to increases in suicide risk. Past research on the association between business cycles and U.S. suicide indicate that the overall suicide rate rises and falls in connection with the economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.

62. Is social media use to blame for increasing suicide rates?

More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

New opportunities for tracking suicide and understanding comprehensive suicide prevention efforts

- **Linking NVDRS with Departments of Defense and Veterans Affairs data on suicide**
  - Partners who are working on this project include Department of Veterans Affairs, Department of Defense Suicide Prevention Office, and the Psychological Health Center of Excellence/Defense Health Agency.
  - This project will link pertinent data on active duty Military and Veteran suicide decedents across CDC's National Violent Death Reporting System (NDVRS), the Department of Defense Suicide Event Reports, and the Veteran Health Administrative databases.

- Provide more information on suicides among active duty Military personnel and Veterans as well as partition study populations in the NVDRS (e.g., civilians, active duty, VHA Veterans, non-VHA Veterans).
- Help agencies monitor common and unique precipitating factors of suicide captured in NVDRS by group/population and inform comprehensive community-based efforts to help address specific population needs. All linkages will use a de-identified matching technique. No personal identifying information will be used.

- **Social media intervention**
  - The purpose of this project is to implement, test, and refine a web-based peer-to-peer therapeutic support platform for U.S. Military Veterans aimed at preventing suicide and related problems.
  - This system called TalkVet, has the potential to bridge the gap between the many social media sites that are widely used by Veterans (e.g., Facebook, Snapchat, etc.) and the growing number of clinical interventions that are available to Veterans, but currently under-utilized.
  - With the explicit consent of users, we will test the novel features of the TalkVet platform in three ways:
    1. Use an artificial intelligence (AI) guided system to help identify participating Veterans most in need of help based on their posts and other user activity;
    2. Connect Veterans in need of help with other Veterans in TalkVet who can support them; and
    3. Conduct outreach with experimentally refined methods for Veterans in need of a higher level of care to encourage them to obtain such care in the form of links and hand-offs provided by the TalkVet system (this phase of the work will include the use of Veteran moderators with training in crisis counseling who will work with our team).
  - This project includes partners from Harvard University, West Virginia University ICRC, TalkLife/Talk/Vet and has been approved by CDC-F.

- **Colorado Collaborative for a Comprehensive Approach to Suicide Prevention**
  - The CDC is collaborating with the Colorado Department of Public Health and Environment, the CDC-funded Injury Control Research Center (ICRC-S), the Colorado National Collaborative (CNC), and the Colorado Suicide Prevention Commission on the first state-wide, large-scale, population-based initiative to reduce suicide rates 20% by 2024 in CO and to serve as a model for other states to help reduce suicide by 20% by 2025 in the nation. Partners on the CNC also include the Action Alliance, SAMHSA, and AFSP, among others.
  - Through this project we propose to pilot test the implementation and evaluation of a comprehensive, integrated approach to suicide prevention—guided, in part, by the CDC's technical package and the National Action Alliance for Suicide Prevention's (NAASP) *Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention*.
  - Working with CDC/F to seek external funding
  - Why Colorado?
    - Colorado consistently ranks among the states with the highest suicide rates in the nation (rate: 19.5 per 100,000 in 2015—U.S. rate 13.3 per 100,000).
    - Colorado has sizable populations at increased risk of suicide, including veterans, American Indian/Alaska Natives (AI/AN), and people living in rural communities.
    - Colorado demonstrates readiness as evidenced by a strong state suicide prevention infrastructure, a history of political will, and a proven track record of valuing and implementing public health approaches to prevention. Specifically, the State has:
      - A funded Office of Suicide Prevention (OSP; legislated in 2000)
      - Suicide Prevention Commission (legislated in 2014)
      - Colorado National Collaborative (est. 2015)
      - A strong platform of existing suicide prevention activity
      - A commitment to 'connecting the dots'/shared risk and protective factors

Select Recent CDC Research

- CDC has released several publications recently.
    - Late last year, we released a JAMA article analyzing the number of youth visiting emergency rooms with nonfatal, self-inflicted injuries.
        - We found that self-inflicted injuries are one of the strongest risk factors for suicide. Our research found that emergency room visits for self-inflicted injuries among young females increased significantly in recent years (2001-2015)-particularly among girls 10-14.
        - And since the risk leads to a potentially fatal outcome, monitoring trends in Self-inflicted injuries is critical to preventing suicide in young people.
            - Mercado MC, Holland K, Leemis RW, Stone DM, Wang J. Trends in Emergency Department Visits for Nonfatal Self-inflicted Injuries Among Youth Aged 10 to 24 Years in the United States, 2001-2015. *JAMA*.2017;318(19):1931–1933. doi:10.1001/jama.2017.13317

    - In February of this year, CDC released a Morbidity and Mortality Weekly Report (MMWR) summarizing 2014 data from the 18 states participating in the National Violent Death Reporting System (NVDRS) at that time.
        - Violent deaths due to self-inflicted injury or interpersonal violence disproportionately affected people aged 45-64~~over age 65,~~ men, and American Indian/Alaska Natives~~, and certain minority populations~~.
        - There were several primary precipitating factors for both homicides and suicides that stood out including: intimate partner problems, interpersonal conflicts, mental health and substance abuse conditions~~problems~~, and recent crises
        - NVDRS is currently in 40 states, the District of Columbia, and Puerto Rico, with goals to expand nationally.
        - Developing and expanding NVDRS is crucial to public health efforts at the federal, state, and local levels, in order to identify information like precipitating factors and also to target prevention efforts.
            - Fowler KA, Jack SP, Lyons BH, Betz CJ, Petrosky E. Surveillance for Violent Deaths — National Violent Death Reporting System, 18 States, 2014. MMWR Surveill Summ 2018;67(No. SS-2):1–36.

    - As part of our commitment to suicide prevention in vulnerable populations, in March of this year, CDC released another MMWR, specifically on suicides among American Indian/Alaska Natives.
        - It showed that the rates of suicide among American Indian/Alaska Natives have been increasing since 2003.
        - Analysis of the data from 18 states, showed that AI/AN people who died by suicide were younger and were more likely to live in a non-metropolitan area than non-Hispanic whites who died by suicide.
        - The data show a clear need for culturally relevant intervention strategies for this population. Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. MMWR Morb Mortal Wkly Rep 2018;67:237–242.

Partner Activities

1. *What is the National Action Alliance for Suicide Prevention?*

   The National Action Alliance, also referred to as the "Action Alliance" is a public-private partnership that works to advance the National Strategy for Suicide Prevention and make suicide prevention a national priority.

2. *What is the National Strategy for Suicide Prevention?*
   This is a report created by the U.S. Surgeon General and the Action Alliance. It emphasizes the role everyone can play in protecting their friends, family, and colleagues from suicide. It has been revised to include a decade of research and other advancements in order to provide guidance for several sectors like schools, businesses, and health systems.

3. *What is Project 2025?*
   Project 2025 is a collaborative initiative developed by American Foundation of Suicide Prevention (AFSP). The goal of Project 2025 is to reduce the annual suicide rate 20 percent by year 2025. AFSP has determined a series of actions and critical areas to help reach the goal, which includes approaches that reach across all demographic and sociological groups.

4. *What is the Action Alliance's Zero Suicide Model?*
   This a key concept of the National Strategy for Suicide Prevention. It requires that health and behavioral health care systems commit to making suicide prevention a core priority and implement processes and strategies that prevent suicide and improve the care of patients at risk for suicide.

Additional Resources

Recommendations for Media about Safe Reporting on Suicide, reportingonsuicde.org

If you or someone you know is thinking about suicide or needs support, help is always available. Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or visit http://suicidepreventionlifeline.org

Preventing Suicide: A Technical Package of Policy, Programs, and Practices: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf.

National Strategy for Suicide Prevention, http://actionallianceforsuicideprevention.org/national-strategy-suicide-prevention-0

Suicide Prevention Resource Center, https://www.sprc.org/

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 22 Jun 2018 09:10:33 -0400
To: Wilkniss, Sandra
Cc: Coleman, Akeiisa;Dennehy, Heather (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar - CDC introduction slides

Thanks for the feedback, will do.

From: Wilkniss, Sandra
Sent: Friday, June 22, 2018 7:00 AM
To: Black, Erin (CDC/ONDIEH/NCIPC)
Cc: Coleman, Akeiisa ; Dennehy, Heather (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Re: June 22 webinar - CDC introduction slides

Great. thanks, Erin. Just one note to consider - most on the call likely won't be familiar with some of the policy options language (eg alcohol outlet density, greening), but will be very interested in any recommended policy options. So, can you take a minute to explain each in lay terms? thanks!

On Jun 21, 2018, at 11:03 AM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

Attached are the talking points I was thinking of sharing:

- In March, in Denver, Colorado, DVP collaborated with the National Governor's Association and SAMHSA to convene state leaders from 13 states with a high burden of suicide to hear suicide prevention best practices from the Indian Health Service, the VA, SAMHSA, and CO state who is implementing a comprehensive suicide prevention pilot.
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from our suicide prevention technical package that we know work to prevent suicide.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 4:58 PM
To: Coleman, Akeiisa <AColeman@NGA.ORG>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Wilkniss, Sandra <SWilkniss@NGA.ORG>
Subject: RE: June 22 webinar - CDC introduction slides

Here are my slides as well! Thanks!
Deb

From: Coleman, Akeiisa <AColeman@NGA.ORG>
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To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Wilkniss, Sandra <SWilkniss@NGA.ORG>
Subject: RE: June 22 webinar - CDC introduction slides

Thanks Alex!
Akeiisa Coleman, MSW
Senior Policy Analyst, Health Division
National Governors Association
202.624.5344 | acoleman@nga.org

From: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
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Subject: RE: June 22 webinar - CDC introduction slides

Greetings:
I have attached the slides.
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Subject: Re: June 22 webinar

Wonderful!

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It looks like I am available on the 22nd for the webinar & on Weds, 20th for the pre-brief.
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Cc: Coleman, Akeiisa <AColeman@NGA.ORG>, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>, Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>, Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar
Great. Will send and invitation for Wednesday at 3:30-4. I could talk later in the day on Monday if you want to do it sooner, but am stuck before noon. thanks!
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To: Wilkniss, Sandra
Cc: Coleman, Akeiisa; Crosby, Alexander (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Dennehy, Heather (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar
Yes, it would be helpful if you could schedule a pre-brief next week. From a quick peek at calendars it looks like Alex, Deb and myself might be available Monday 10:30-11 or Wed 3:30-4.

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Subject: Re: June 22 webinar
Hello Erin and Dr Stone.
We can be flexible in the federal overview and take your lead on the data to highlight as well as any priority strategies, federal-state partnership aimed at preventing suicide you would like to share. May we schedule a call with the three of you for when Alex returns early next week to plan? Thank you!
Sandra

On Jun 14, 2018, at 11:19 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Ladies – what does the federal overview in the agenda below consist of? As mentioned I plan to be on the call, also the Vital Signs lead author, Deb Stone (copied), will be on the call to present on the Vital Signs. Alex is currently on leave but back next week to discuss his availability.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 14, 2018 1:25 PM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Coleman, Akeiisa <AColeman@NGA.ORG>
> **Subject:** June 22 webinar
>
> Hi again, Erin. We just discussed the layout for this webinar and wanted to bullet it out for you for discussion you are having at CDC:
> Call is June 22 from 2 – 3pm eastern with governors health policy adivisors (all states and territories invited)
> 5 minutes flex time for people to get on the call and announce themselves
> 10 min federal overview
> 2 min overview of what to expect – NGA
> 5-7 min CDC talking about recent data
> 5-7 min NGA to summarize meeting highlights
> 5-7 min state rep from CO to talk about their comprehensive approach
> 5-7 min ID/UT rep to talk about prevention or partnership (this is being nailed down in the next couple days)
> 15 min Q & A
> We will be able to show slides.
> I hope this helps!
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 14, 2018 10:50 AM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
>
> HI Erin,
> It is still being reviewed internally. So, we had hoped to do the webinar after the paper was done. However, the opportunity on the 22nd came up and we thought it more important to capitalize on the momentum of your recent report rather than wait for our paper to be final. We think it critical to get attention to the issue while its top of mind. Sound ok?
>
> **From:** Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]

Sent: Thursday, June 14, 2018 10:25 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Have you sent us a copy of the report yet from the convening that you will be discussing on the call? I will be on the call but also still confirming if others will attend. Alex is out until Monday.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 9:49 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: Re: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin -

We have all things ready to go for the webinar next Friday. Are you ok to cover the new data and/or can others join the call? We are super excited to highlight and get the info to all governors. Thanks!

On Jun 12, 2018, at 1:30 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Sandra – I am available that day/time – but let me check internally and see who would be best to present on the VS and get back to you.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Tuesday, June 12, 2018 9:00 AM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
>
> Good morning Erin, Alex, Malia and Heather,
> Thanks again for this terrific report! We are updating the paper now with new stats. In the meantime, we have had an opening for our state leadership calls for June 22 2-3pm eastern which we could use to highlight the findings of the Vital Signs report and lessons learned from our meeting and we have a couple of states available to give brief comments about their strategies. I am hoping that it is possible for you all to be available that

day/time for the webinar with governors health policy advisors? It is usually very well attended and may help perpetuate the momentum around your report. Please let me know if it's possible and we can jump on a call and sort out details. Thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 1:34 PM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

I will be on leave July 16-20 and in an all-day meeting July 31.

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Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hello Erin and Team. Congratulations! We can't wait to review and will incorporate into the white paper and will share with our folks. The date for the webinar has not yet but set, but we are looking at July. Would it be possible for you to let us know of dates that do not work in July for at least one of your team to join and share the Vital Signs highlights? Thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 9:56 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia

(CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Sandra and Akeiisa,

As we mentioned, our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* will be released later today. The report includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions.

The CDC celebrates the National Governors Association's commitment to creating safe communities. We hope that this resource can provide state leaders with an increased understanding of the impact of suicide in their states, as well as potential solutions for prevention.

I would appreciate it if you could help disseminate the Vital Signs to your networks once the embargo lifts at 1:00 pm. Also, as discussed we will plan to highlight the Vital Signs on the planned Webinar with State health policy advisors (has a date been set yet?).

Erin

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet.

This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at

1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

The information contained in this electronic transmission, including any attachments, is for the exclusive use of the intended recipient(s) and may contain information that is privileged,

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From: Dennehy, Heather (CDC/ONDIEH/NCIPC)
Sent: 21 Jun 2018 14:04:29 -0400
To: Coleman, Akeiisa;Wilkniss, Sandra
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar - CDC introduction slides
Attachments: vs-0618-suicide-H.pdf, NVDRS-factsheet.pdf, Success Stories NVDRS_2015.pdf, Examples of Suicide Data From CDC.PDF

Hi Akeiisa,
We also put together a couple of "handouts" we thought might be helpful to share with webinar attendees.

- The Vital Signs Fact Sheet
- NVDRS Fact Sheet
- NVDRS Stories from the Field (how states are currently using the system)
- Examples I just pulled to give an idea of the kind of information (maps, cost data, burden data, etc.) that you can access from our CDC web page.

Let me know if you have questions on anything. Thanks again for all your help making this happen!
Heather

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Cc: Dennehy, Heather (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar - CDC introduction slides

Thanks Erin! These look great.
Akeiisa Coleman, MSW
Senior Policy Analyst, Health Division
National Governors Association
202.624.5344 | acoleman@nga.org

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Sent: Thursday, June 21, 2018 11:03 AM
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Subject: RE: June 22 webinar - CDC introduction slides

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Akeiisa Coleman, MSW
Senior Policy Analyst, Health Division
National Governors Association
202.624.5344 | acoleman@nga.org

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Subject: Re: June 22 webinar
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> **Sent:** Thursday, June 14, 2018 11:25 PM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Coleman, Akeiisa <AColeman@NGA.ORG>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
> **Subject:** Re: June 22 webinar
> Hello Erin and Dr Stone.

We can be flexible in the federal overview and take your lead on the data to highlight as well as any priority strategies, federal-state partnership aimed at preventing suicide you would like to share. May we schedule a call with the three of you for when Alex returns early next week to plan? Thank you!
Sandra

On Jun 14, 2018, at 11:19 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Ladies – what does the federal overview in the agenda below consist of? As mentioned I plan to be on the call, also the Vital Signs lead author, Deb Stone (copied), will be on the call to present on the Vital Signs. Alex is currently on leave but back next week to discuss his availability.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 14, 2018 1:25 PM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Coleman, Akeiisa <AColeman@NGA.ORG>
> **Subject:** June 22 webinar
>
> Hi again, Erin. We just discussed the layout for this webinar and wanted to bullet it out for you for discussion you are having at CDC:
> Call is June 22 from 2 – 3pm eastern with governors health policy adivisors (all states and territories invited)
> 5 minutes flex time for people to get on the call and announce themselves
> 10 min federal overview
> 2 min overview of what to expect – NGA
> 5-7 min CDC talking about recent data
> 5-7 min NGA to summarize meeting highlights
> 5-7 min state rep from CO to talk about their comprehensive approach
> 5-7 min ID/UT rep to talk about prevention or partnership (this is being nailed down in the next couple days)
> 15 min Q & A
> We will be able to show slides.
> I hope this helps!
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 14, 2018 10:50 AM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
>
> HI Erin,
> It is still being reviewed internally. So, we had hoped to do the webinar after the paper was done. However, the opportunity on the 22nd came up and we thought it more important to capitalize on the momentum of your recent report rather than wait for our paper to be final. We think it critical to get attention to the issue while its top of mind. Sound ok?
>
> **From:** Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
> **Sent:** Thursday, June 14, 2018 10:25 AM
> **To:** Wilkniss, Sandra <SWilkniss@NGA.ORG>

Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Have you sent us a copy of the report yet from the convening that you will be discussing on the call? I will be on the call but also still confirming if others will attend. Alex is out until Monday.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 9:49 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: Re: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin -

We have all things ready to go for the webinar next Friday. Are you ok to cover the new data and/or can others join the call? We are super excited to highlight and get the info to all governors. Thanks!

On Jun 12, 2018, at 1:30 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Sandra – I am available that day/time – but let me check internally and see who would be best to present on the VS and get back to you.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Tuesday, June 12, 2018 9:00 AM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
>
> Good morning Erin, Alex, Malia and Heather,
> Thanks again for this terrific report! We are updating the paper now with new stats. In the meantime, we have had an opening for our state leadership calls for June 22 2-3pm eastern which we could use to highlight the findings of the Vital Signs report and lessons learned from our meeting and we have a couple of states available to give brief comments about their strategies. I am hoping that it is possible for you all to be available that day/time for the webinar with governors health policy advisors? It is usually very well attended and may help perpetuate the momentum around your report. Please let me know if it's possible and we can jump on a call and sort out details. Thanks!
> Sandra
>
> **From:** Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
> **Sent:** Thursday, June 7, 2018 1:34 PM
> **To:** Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>

Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

I will be on leave July 16-20 and in an all-day meeting July 31.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 7, 2018 1:27 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hello Erin and Team. Congratulations! We can't wait to review and will incorporate into the white paper and will share with our folks. The date for the webinar has not yet but set, but we are looking at July. Would it be possible for you to let us know of dates that do not work in July for at least one of your team to join and share the Vital Signs highlights? Thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 9:56 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Sandra and Akeiisa,
As we mentioned, our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* will be released later today. The report includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions.
The CDC celebrates the National Governors Association's commitment to creating safe communities. We hope that this resource can provide state leaders with an increased understanding of the impact of suicide in their states, as well as potential solutions for prevention.

I would appreciate it if you could help disseminate the Vital Signs to your networks once the embargo lifts at 1:00 pm. Also, as discussed we will plan to highlight the Vital Signs on the planned Webinar with State health policy advisors (has a date been set yet?).
Erin

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and

search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

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#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



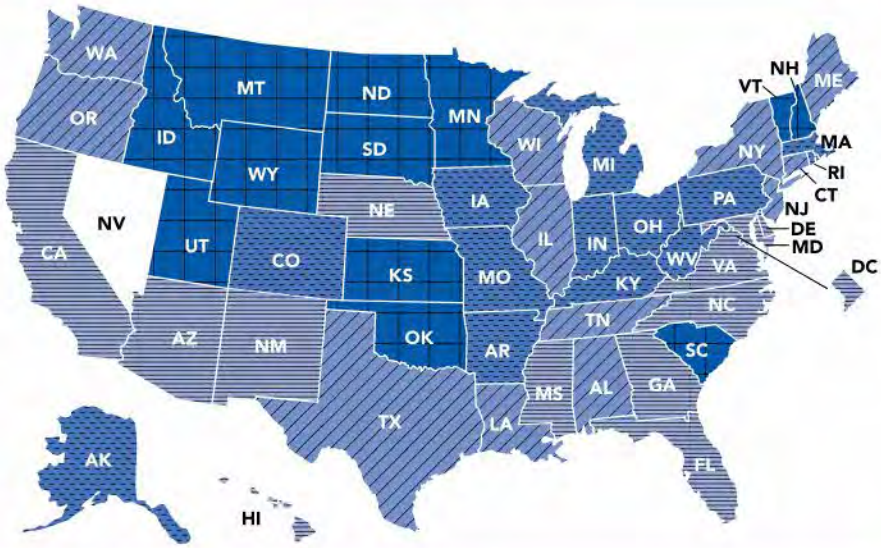
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

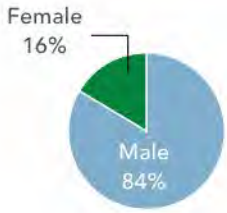


Differences exist among those with and without mental health conditions.

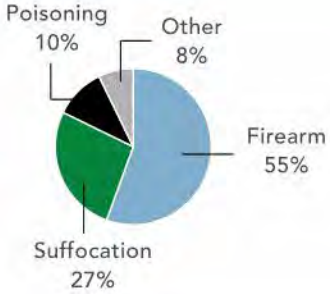
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

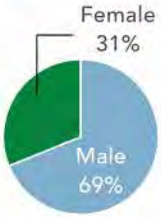


Method

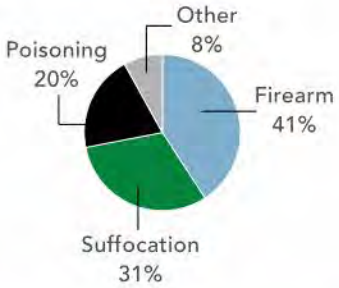


Known mental health conditions

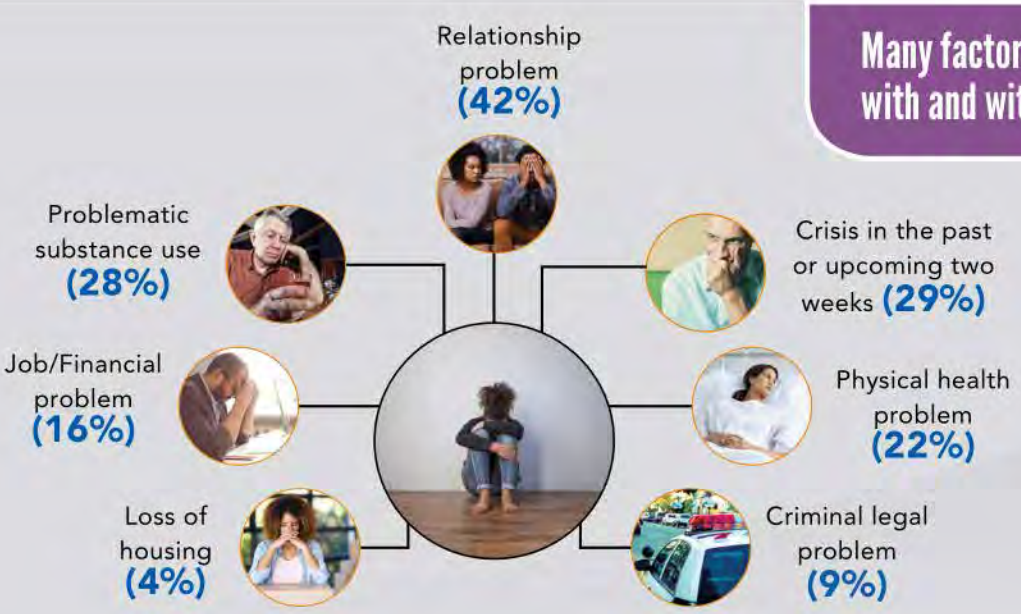
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018

CDC's National Violent Death Reporting System (NVDRS)

Violence is a Major Public Health Problem

In the United States, seven people per hour die a violent death. More than **19,000 people were victims of homicide** and almost **45,000 people died by suicide** in 2016 alone. The economic costs are staggering—with suicide costing the U.S. economy **$57 billion** and homicide **$30 billion**, and this is just the costs for medical care and lost work. Other costs, including the emotional toll on victims' families and the costs to the criminal justice system for arrest and incarceration of offenders are substantial and not included in this estimate. Also, many Americans survive violent experiences and are left struggling with long-term physical, psychological, and emotional consequences. Violence erodes entire communities—reducing productivity, decreasing property values, disrupting social services, and making people feel unsafe in the places where they live, work, and learn.

A Comprehensive Look at Violent Deaths

NVDRS covers all types of violent deaths—including homicides and suicides—in all settings and for all age groups. NVDRS includes **over 600 unique data elements** that provide valuable context about violent deaths such as relationship problems; mental health problems and treatment; toxicology results; and life stressors, including recent problems with a job, finances, or physical health problems. Extensive information about the incidents, such as weapons used, characteristics of suspects, and locations where they occurred are included. Such data are far more comprehensive than what is available elsewhere.

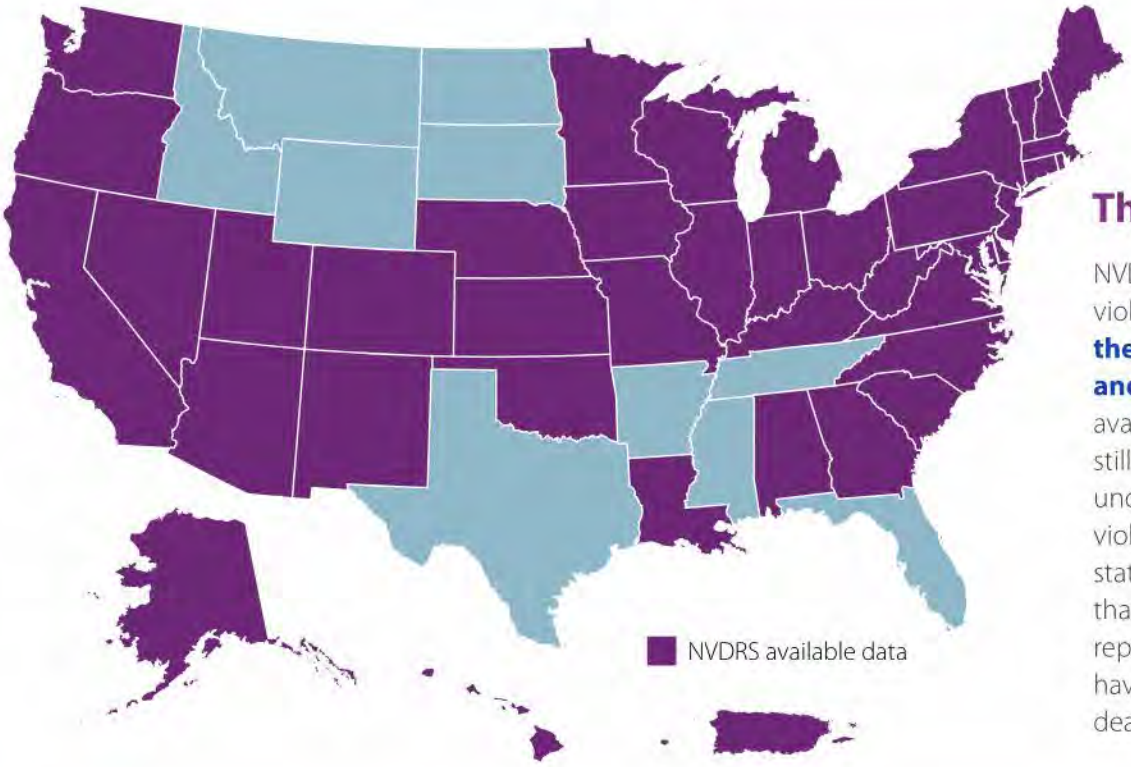
Linking Data to Get the Whole Story

To help find answers to prevent violent deaths, we need to know the facts. CDC's NVDRS links information about the **"who, when, where, and how"** from data on violent deaths and provides insights about **"why"** they occurred.

Frontline investigators including law enforcement, coroners, and medical examiners collect valuable information about violent deaths. However, these data are seldom combined in a systematic manner to provide a complete picture.

NVDRS provides a clearer understanding of violent deaths. NVDRS is the only state-based surveillance (reporting) system that pools data on violent deaths and their circumstances from multiple sources into one anonymous database. No personally identifiable information is collected.

National Center for Injury Prevention and Control
Division of Violence Prevention



The Reach of NVDRS

NVDRS pulls together data on violent deaths in **40 states, the District of Columbia, and Puerto Rico**. If data are not available for your state, you can still use NVDRS data to better understand general patterns of violent deaths in participating states. However, keep in mind that NVDRS data are not nationally representative. We still do not have a complete picture of violent deaths across the nation.

What NVDRS Can Do

- **Inform decision makers** and program planners about the magnitude, trends, and characteristics of violent deaths.
- **Educate your community** about circumstances that contribute to violence in your county, state, or territory.
- **Develop and tailor** violence prevention efforts to maximize benefits.
- **Evaluate the impact** of prevention programs and strategies.

Accessing NVDRS

CDC's Injury Center distributes information from NVDRS at the state and national level in both summary and topic-specific **reports**.

NVDRS data are stored in an incident-based database. Descriptive data can be accessed free of charge from **Web-Based Injury Statistics Query And Reporting System (WISQARS)**.

What Makes NVDRS Unique

Other data systems mainly count deaths and provide basic demographic information. In contrast, NVDRS:

- **Gathers and links** detailed investigative information from several sources, including law enforcement, medical examiners and coroners, toxicology, and death certificates. With this linked information, NVDRS is able to provide a more complete picture of the circumstances that contribute to violent deaths.
- **Helps identify** emerging issues, such as veteran suicide.
- **Combines data about deaths** that occurred during the same violent event to help identify circumstances of multiple homicides or homicides followed by the suicide of the homicide suspect.
- **Collects information** on the suspect and the relationship of the victim to the suspect to better characterize homicides.

CDC provides technical assistance for NVDRS in the form of manuals and complementary resources.

For further information on NVDRS, visit **https://www.cdc.gov/violenceprevention/nvdrs**.

NATIONAL VIOLENT DEATH REPORTING SYSTEM



Stories from the Frontlines of Violent Death Surveillance



About the Safe States Alliance

Established in 1993, the Safe States Alliance is a national non-profit organization and professional association whose mission is to strengthen the practice of injury and violence prevention. Safe States is the only national non-profit organization and professional association that represents the diverse and ever-expanding group of professionals who comprise the field of injury and violence prevention. Safe States Alliance engages in a variety of activities to advance the organization's mission, including:

- Increasing awareness of injury and violence throughout the lifespan as a public health problem;
- Enhancing the capacity of public health agencies and their partners to ensure effective injury and violence prevention programs by disseminating best practices, setting standards for surveillance, conducting program assessments, and facilitating peer-to-peer technical assistance;
- Providing educational opportunities, training, and professional development for those within the injury and violence prevention field;
- Collaborating with other national organizations and federal agencies to achieve shared goals;
- Advocating for public health policies designed to advance injury and violence prevention;
- Convening leaders and serving as the voice of injury and violence prevention programs within state health departments; and
- Representing the diverse professionals making up the injury and violence prevention field.

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NVDRS:
STORIES FROM THE FRONTLINES OF VIOLENT DEATH SURVEILLANCE

FOREWORD

We are pleased to present, ***NVDRS: Stories from the Frontlines of Violent Death Surveillance***, a document designed to communicate the unique capacity of the National Violence Death Reporting System (NVDRS) and the benefits states gain from participating in this nationwide, state-based surveillance system.

The NVDRS links data from vital statistics, medical examiners and coroners, law enforcement, crime laboratories, and other sources to provide – for the first time – a more complete understanding of violent deaths in the U.S., states and local communities. It was established in 2002, is funded by CDC and currently operates in 32 states. The goal is to expand NVDRS participation to all U.S. states and territories.

The stories in this document highlight the experience of several NVDRS states by first telling the story of a typical violent death in the state. Each story is told using the kind of data typically gleaned from NVDRS sources – information about victims and suspects, their relationships, important circumstances contributing to the death, and weapons used. To protect confidentiality, the stories reflect *typical* information, not real deaths.

The document also presents recent rates and trends for specific types of violent deaths – valuable data generated by state violent death reporting systems not feasibly collected, linked and analyzed prior to the NVDRS. These data expand our understanding of factors contributing to violent deaths, from homicide-suicides to suicides related to domestic violence and elder abuse. Also included are exciting examples of how states have translated NVDRS data into actions targeting and informing violence prevention efforts at state and local levels.

We hope you find this an engaging, useful tool for demonstrating the unique capacity of the NVDRS, building support for this surveillance system and helping expand state participation. As this document illustrates, linking data about violence can save lives.

Amber Williams
Executive Director
Safe States Alliance



NVDRS:
STORIES FROM THE FRONTLINES OF VIOLENT DEATH SURVEILLANCE

THE NATIONAL VIOLENT DEATH REPORTING SYSTEM (NVDRS)

Creating a more complete picture of violent deaths

In 2013, a total of 16,121 people were victims of homicide and 41,149 people took their own life, according to the CDC. Valuable information about these and other violent deaths is collected by many sources - law enforcement agents, coroners, medical examiners, crime lab investigators, and state vital records offices. But these data are rarely combined in a systematic way to provide a complete picture of violent incidents - **a picture with details about victims and suspects, their relationships, important circumstances contributing to a death, and weapons used**.

The National Violent Death Reporting System (NVDRS) is a nationwide, state-based surveillance system established in 2002 and funded by CDC to collect data on violent deaths from participating states. The CDC currently funds 32 states, who have each established a state violent death reporting system and voluntarily report state data to CDC.

WHAT IS A VIOLENT DEATH?

According to the CDC: A violent death is a death that results from the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community.

Linking data from multiple sources

The NVDRS collects and links data from four major sources about the same violent death incident:

- Death certificates
- Coroner/medical examiner reports
- Law enforcement reports
- Crime laboratories

Some states may incorporate additional data sources, including Child Fatality Reviews or Domestic Violence Fatality Reviews. After all identifying information is removed, these data are linked in an anonymous state database and submitted to the NVDRS. The names of individual victims and suspects are not released, and laws protecting other types of health department records, such as communicable disease records, also apply to NVDRS files.

The power of an *incident*-based system

While some systems - such as vital statistics - count deaths, the NVDRS collects data on the *entire violent incident*. A single incident can have one or more victims and/or suspects. The NVDRS can identify all victims in a multi-homicide, or link victims and a suspect in a homicide-suicide.

Linking data into one database places a death into context and provides information not previously possible, such as:

- the relationship between the victim and perpetrator, including if they knew each other;
- information about the perpetrator, including criminal history;
- circumstances such as a history of depression or other mental health problems, chronic illness, alcohol or drug use, recent problems with a job, finances or relationships, gang activity, or the recent death of a family member; and
- circumstances unique to intimate partner violence, including prior incidents of abuse.

Translating data into action

The NVDRS provides the nation, states and communities with a clearer understanding of violent deaths and their circumstances by:

- describing the magnitude of and trends for specific types of violence,
- identifying risk factors associated with violence at state and local levels, and
- targeting and guiding state and local violence prevention programs, policies and practices.

CURRENT NVDRS STATES

Alaska • Arizona • Colorado • Connecticut • Georgia • Hawaii • Illinois • Indiana • Iowa
Kansas • Kentucky • Maine • Maryland • Massachusetts • Michigan • Minnesota • New Hampshire
New Jersey • New Mexico • New York • North Carolina • Ohio • Oklahoma • Oregon • Pennsylvania
Rhode Island • South Carolina • Utah • Vermont • Virginia • Washington • Wisconsin

NVDRS: STORIES FROM THE FRONTLINES OF VIOLENT DEATH SURVEILLANCE

TYPICAL DATA FROM NVDRS SOURCES

DEATH CERTIFICATE

- Age
- Gender
- Residence
- Marital status
- Profession
- Employment status
- Veteran status
- Cause of death
- Manner of death
- Time of death
- Pregnancy status

MEDICAL EXAMINER/ CORONER

- Brief narrative of incident
- Demographics
- Wound location
- Weapon information, patterns on victim
- Cause of death
- Manner of death
- Current disease/ health condition
- Current/recent medical treatment
- Current medication
- Relationships among involved persons (if available)
- Circumstances relevant to death

TOXICOLOGY

- Presence or absence of alcohol or drugs in victim(s)

LAW ENFORCEMENT

- Narrative on the circumstances of the death
- Wound locations
- Weapon information
- Relationships among victim, perpetrator, others involved
- Information on suspect(s)
- Potential evidence to substantiate/support conclusion about violent death type (suicide, homicide)
- Presence/absence of suicide note
- Interviews with any witnesses, family members, others
- Critical stressors in victim's life

CHILD FATALITY REVIEW

Information on victim's:

- Household
- Caregivers
- Supervision
- Previous contacts with child protective services
- Relationship with perpetrator

DOMESTIC VIOLENCE FATALITY REVIEW

Information on current/ former girlfriend, boyfriend, date, spouse

- Length of relationship
- Breakup/breakup in progress
- Court/prosecutor & restraining order records
- Domestic-violence related services (safety planning, shelter, lethality assessment)
- Perpetrator criminal history, charge/conviction
- # of children exposed to homicide

CRIME LAB

Firearms involved

- Type, make & model
- Caliber or gauge
- Serial number
- Importer's name & address



DATA ELEMENTS OVERLAP

Same information may come from multiple sources

ALASKA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Alaska Division of Public Health, Injury Surveillance Unit

Collecting data since 2003





A SUICIDE IN ALASKA

To ensure confidentiality, the example below is not the story of an actual death in Alaska. The example was created to illustrate the violent death data typically collected and linked in the Alaska Violent Death Reporting System (AKVDRS).

DEATH CERTIFICATE

A 26-year old female was last seen alive by her sister as she left a family event in a small community. Skeletal remains found several months later near a hiking trail were identified as the victim. Victim died from a self-inflicted gunshot wound to the head. The manner of death was suicide.

MEDICAL EXAMINER

The victim was a 26-year-old female who died from a single gunshot wound to the head. The victim's remains were found next to a small creek. A forensic odonatologist and a forensic anthropologist were consulted to provide positive identification and assist in identifying the breakage patterns of the skull to determine a probable cause of death.

A review of the victim's medical records indicated she had been seen approximately 11 months prior in a local emergency department for domestic violence-related injuries but otherwise had no significant medical or mental health issues. She had no history of drug or alcohol treatment, but court records indicate a previous arrest for possession of narcotics.

LAW ENFORCEMENT

After being unsuccessful in locating the victim, the family contacted 911. Troopers issued a missing persons notice and initiated a search. On the third day of the search, troopers found the victim's vehicle parked at a popular trail head with the keys in the ignition and the victim's personal belongings inside and untouched. A notebook on the passenger seat contained a suicide note alluding to feeling threatened by her boyfriend and living in fear of his continual "on again, off again" physical and sexual assaults, as well as her frustration of not being able to stop using heroin and the resulting financial burdens.

Hikers found a backpack in a ravine next to a small creek, and upon closer inspection, a portion of the victim's remains in a face down position a short distance from the backpack.

Interviews with family members and friends revealed the victim had made vague suicide ideations in the past, but the family did not think they were serious and did not act. The victim's employer stated that the victim was working as a check-out clerk at a local store and was recently disciplined for poor performance.

TOXICOLOGY

Postmortem toxicological studies (tissue only) determined the victim had used heroin prior to her demise.

ALASKA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Alaska Division of Public Health, Injury Surveillance Unit

Collecting data since 2003



THE BIG PICTURE

Alaska Violent Death Reporting System (AKVDRS) data show that suicide is a significant public and mental health issue in Alaska.

- Alaska had the second highest suicide rate in the nation in 2013.
- During 2009-2013 in Alaska, **suicide was the leading cause of death** among Alaskans ages 15-44, the sixth leading cause of death overall, and the **most common type of violent death** (62%).

Among the 798 suicide deaths recorded in Alaska during 2009-2013:

- Males, young adults, American Indian/Alaska Native people, and persons living in rural regions of the state had the highest suicide rates
- The vast majority (92%) had at least one of the mental health problems and/or other life stressors highly associated with suicide
- Alcohol intoxication and current depressed mood were the most common suicide characteristics, and 22% had a known alcohol or substance abuse problem (dependency)
- Intimate partner problem was often identified (33%); 59 (5%) decedents perpetrated intimate partner violence within the past month
- 26 (3%) decedents killed at least one other person before taking his/her own life, **resulting in 14 homicide deaths**
- Gunshot injury was the most common cause of death (males: 427/631, 68%; females: 79/158, 50%), followed by hanging/strangulation/suffocation and poisoning
- 169 (21%) were current or former U.S. military personnel; with about 15% of the Alaska population composed of current or former U.S. military personnel, this population may be at increased risk for suicide in Alaska

Intimate partner problem identified in **33%** of suicides

TRANSLATING DATA INTO ACTION

Improving quality of veteran suicide data

Collaboration and data sharing between the AKVDRS and Alaska Suicide Prevention programs (municipal, state, tribal, and veteran) resulted in:

- Improved identification of suicide victims particularly those individuals qualifying for veteran services, when "military experience" is reflected on death certificates
- Expanded data on the circumstances around family/domestic violence and veteran suicides, such as if the victim was engaged with mental health services

Improving suicide prevention & postvention

- **AKVDRS data have been used to develop prevention strategies** such as the **Alaska State Suicide Prevention Plan**, and inform interventions with those most at risk for suicide. These strategies include the **Applied Suicide Intervention Skills Training** to help caregivers become more willing, ready and able to help persons at risk, and **Gatekeeper Training** that teaches anyone – public or private – how to determine if a person is at risk and connect them to help.
- Local and tribal health care facilities serving veterans have used **AKVDRS data on veterans' engagement with mental health services to improve these services and suicide prevention efforts.**
- **AKVDRS data on suicide circumstances and local suicide patterns help inform state and local "postvention" efforts after a suicide,** especially among small villages where suicide may run in families or groups.
- **Postvention is a best practice** to document and understand a suicide death, help answer the question of "why?", and improve suicide prevention efforts. Postvention supports family, friends and others affected by the suicide, and aims to reduce suicidal behavior among these surviving individuals and break the chain of events that lead to self-harm.



MASSACHUSETTS Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Massachusetts Department of Public Health, Injury Surveillance Program

Collecting data since 2003



DEATH CERTIFICATE

- Homicide victim: 43-year-old white female
- Suicide victim: 52-year old white male

MEDICAL EXAMINER

- Female died from 4 gunshots to torso
- Male died from 1 gunshot to head

LAW ENFORCEMENT

- Co-worker stated victim had broken up with suspect 10 days ago
- No prior reports of domestic violence

A HOMICIDE-SUICIDE IN MASSACHUSETTS

The example below tells the story of a suicide in Massachusetts, but to ensure confidentiality, it is not the story of an actual death. The example was created to illustrate the violent death data typically collected and linked in the Massachusetts Violent Death Reporting System (MAVDRS).

DEATH CERTIFICATE

The victim was a 43-year-old white female. She was injured and died in her residence from gunshot wounds. The manner of death was homicide. She was an office secretary. Another victim was a 52-year-old white male. He died at the scene from a gunshot wound to the head. The manner of death was suicide. He was a laborer working in construction.

MEDICAL EXAMINER

Police responded to the victim's residence. The victim, a 43-year-old white female, died from 4 gunshot wounds to her torso. A second victim, a 52-year-old white male, was also at the scene. He died from a self-inflicted gunshot wound to the head. The male is suspected of killing the female, and then killing himself. The victims were intimate partners.

TOXICOLOGY

Both the victim and the boyfriend had negative toxicology results.

LAW ENFORCEMENT

When the victim, a 43- year-old white female, did not show up for work, the victim's co-workers called police to assist in a well-being check. Police responded to the victim's residence and found her on the floor of the living room with gunshot wounds to her torso. Upon further investigation, police discovered the body of a 52-year-old white male in the rear of the home with a gunshot wound to his head. A co-worker on the scene stated that the deceased male was the victim's estranged boyfriend. The co-worker stated the victim had broken up with the boyfriend 10 days prior after a relationship of many years.

The victim and the boyfriend had one minor child, a 4-year-old son, between them. The child was not at home at the time of the incident. The child was with his grandmother, the victim's mother, who lives nearby. The victim's mother told law enforcement that the victim had complained to her that the boyfriend would get very angry whenever the victim talked about breaking up.

According to police reports, there were no prior incidents of domestic violence reported. Family and neighbors also were unaware of any domestic disturbance between the victim and the boyfriend.

MASSACHUSETTS Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Massachusetts Department of Public Health, Injury Surveillance Program

Collecting data since 2003



THE BIG PICTURE

Homicide-suicide incidents are rare but violent events with long-lasting effects on families and communities. From 2003-2007 in Massachusetts, there were 41 homicide-suicide incidents in the state that resulted in 49 homicides and 41 suicides, for a total of 90 deaths, per Massachusetts Violent Death Reporting System (MAVDRS) data.

Among the 41 homicide-suicide incidents (in which the fatal injuries were inflicted less than 24 hours apart) during 2003-2007, most were:

- intimate partner violence-related,
- perpetrated by white males,
- involved the use of a firearm,
- did not involve an intoxicated perpetrator,
- had homicide victims who were female and older than all other homicide victims on average, and
- had perpetrators who were known to the homicide victim.

41%

homicide-suicide incidents resulted in **49** homicides & **41** suicides (90 deaths)

TRANSLATING DATA INTO ACTION

Capturing new information

Before the MAVDRS, there was no official way to capture information on homicide-suicide incidents because existing surveillance systems were *person-based*.

- **The MAVDRS is *incident-based*, which enables identification of multiple deaths from the same incident or between victims and suspects**, and provides a better understanding of the violent deaths.
- Without the MAVDRS, important differences between homicide-suicides and separate, unrelated homicides or suicides could be missed.

Sharing new information

New information about violent deaths is available through the MAVDRS, and the Injury Surveillance Program has disseminated these findings through 7 annual data reports, 4 special bulletins and many responses to data requests. For example, the program:

- identified and disseminated new **findings about an increase in suicides among middle aged white males**,
- identified and disseminated new findings about an increase in multiple-victim incidents in general, and particularly among homicide-suicide incidents,
- is **tracking the emerging issue of suicide by hydrogen sulfide**, which results from mixing household chemicals – chemicals that can produce fumes dangerous to first responders and other people living in the building where an incident occurs;
- **analyzed train-related death data** for the state suicide prevention program;
- **analyzed youth-related violent death data** for the governor's Safe and Successful Youth Program; and
- regularly responds to a variety of **data requests from counties, cities and towns**.

Improving data quality

Because it **double checks data from each source and corrects coding mistakes**, the MAVDRS has improved the quality of data from Vital Records, medical examiners and law enforcement.

Improved collaboration

Other benefits of implementing the MAVDRS are **improved relationships and data sharing among public health, medical examiners and law enforcement agencies**. Improved collaboration with the Boston Police Department has increased the amount of information on circumstances and suspects that the agency shares with the Injury Surveillance Program.

MAVDRS identifies multiple deaths from the same incident, connects victims & suspects

MAVDRS improved data sharing between public health & Boston Police Department

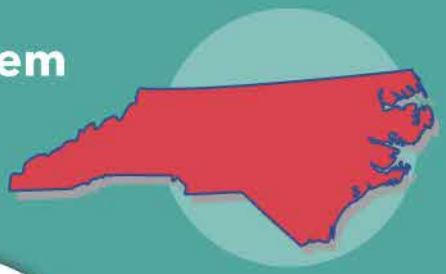
MAVDRS can track emerging issues, e.g. suicide by hydrogen sulfide (household chemicals)

NORTH CAROLINA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the North Carolina Division of Public Health, Injury & Violence Prevention Branch

Collecting data since 2004





AN ELDER ABUSE SUICIDE IN NORTH CAROLINA

The example below tells the story of a suicide in North Carolina, but to ensure confidentiality, it is not the story of an actual death. The example was created to illustrate the violent death data typically collected and linked in the North Carolina Violent Death Reporting System (NC-VDRS).

DEATH CERTIFICATE

The victim was a 62 year old male who died from an intentional overdose of methadone.

MEDICAL EXAMINER/ CORONER

The victim was a 62 year old male who was found unresponsive in his residence by a family member who checked on him every morning. EMS was called and the victim was pronounced dead on the scene. The victim had many health problems which resulted in significant pain. He was prescribed methadone to control the pain. According to his friends, the victim felt his condition was worsening and didn't feel that he would get any better. The victim also had been diagnosed with bipolar disorder and was receiving treatment. The victim was described as depressed in the weeks leading up to his death due to his health condition and limited finances. There was no information on whether the victim had ever attempted or threatened suicide in the past and he did not leave a note. It was determined that the victim died from an intentional overdose of methadone.

LAW ENFORCEMENT

The victim was a 62 year old male who was found unresponsive in his residence after a family member requested authorities do a welfare check on the victim. The victim was found lying unresponsive inside his home with an empty medication bottle lying nearby. According to his family, the victim suffered from chronic pain after being injured in a motor vehicle crash several years earlier. He was prescribed methadone to control the pain and was noted to abuse his medication. This addiction to prescription medication led to the victim using crack cocaine as well. The victim had been diagnosed with bipolar disorder and was receiving treatment. He was described as depressed in the weeks leading up to his death due to his addiction, which had resulted in financial problems. The victim had attempted suicide in the past but the method is not known. The victim did not leave a note.

ADULT PROTECTIVE SERVICES

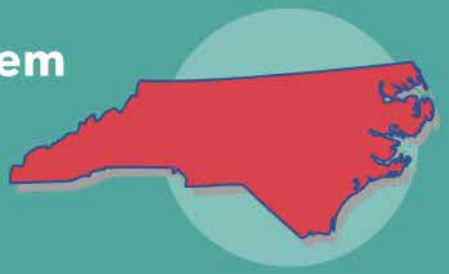
Several reports were made due to self-neglect and concern from the victim's family. The victim was known to have a long psychiatric history and was not compliant with his medication. The victim had been involuntarily committed on several occasions and attempted suicide twice by overdose. The reports were substantiated and the victim last had contact with the Department of Social Services a year prior to his death.

NORTH CAROLINA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the North Carolina Division of Public Health, Injury & Violence Prevention Branch

Collecting data since 2004



THE BIG PICTURE

Elder maltreatment is an increasing problem across the U.S., and this maltreatment may contribute to suicide and homicide among older adults. Data from the North Carolina Violent Death Reporting System (NC-VDRS) show that **for the 652 elder North Carolina residents who died as a result of violence from 2008 to 2009,**

- 530 (81%) were suicide-related,
- 34% of all elder males and 48% of elder females had been characterized as having a current mental health problem by a medical professional, and
- 32% of males and 31% of females disclosed their intention to commit suicide to someone else.

Older adults, disabled adults and disabled emancipated minors served by North Carolina's Adult Protective Services may be particularly vulnerable to abuse and neglect, and at risk for a violent death.

81%

of the **652** elder deaths from violence in 2008-2009 were suicide-related

TRANSLATING DATA INTO ACTION

Few states have surveillance systems which allow them to adequately understand the magnitude of elder maltreatment in their state. **North Carolina improved its elder maltreatment surveillance by linking data from the North Carolina Violent Death Reporting System (NC-VDRS) with records from the Division of Aging and Adult Services' Adult Protective Services (APS),** which works through 100 county social services departments to identify and serve adults in need of protective services.

New linked data

North Carolina quantified and described – **for the first time** – violent deaths among persons age 18 and above in care of APS. During 2005-2008:

- Most APS deaths were among females, **but males accounted for over 60% of violence-related APS deaths.**
- **Violence-related APS deaths occurred most often among persons ages 45-54,** while all other types of APS deaths occurred most often over age 75.
- Among adults in APS care who died from suicide, over 70% were identified as having a mental health diagnosis and almost 70% were receiving treatment at the time of their death.

Case-level data

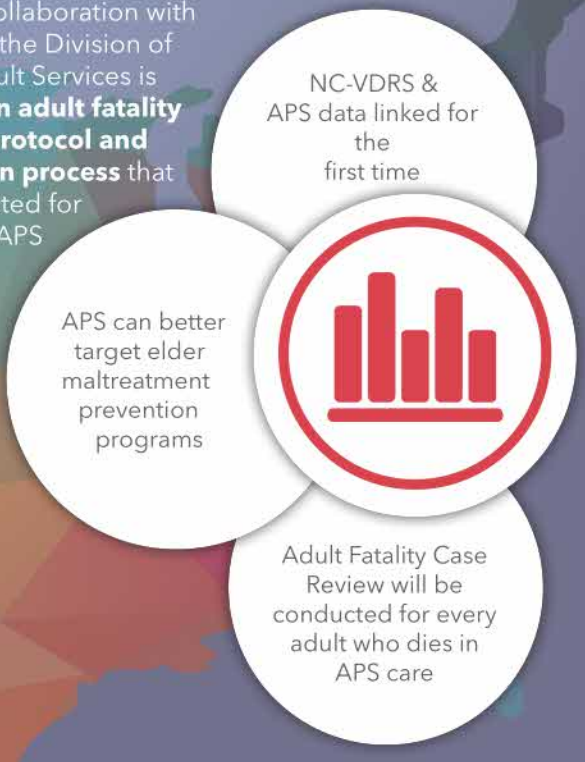
Linking NC-VDRS and APS data provided important *case-level information,* including if the person had ever been or was currently in APS care at the time of death, and if so, the county social service involved at the time of death, the length of time in this care, and the type of protective services received.

Targeted services & improved programs

The Division of Aging and Adult Services used the linked data to work with APS in counties where these deaths occurred to **better target elder maltreatment prevention programs and improve staff training to identify violent death risks,** such as indications of suicidal ideation or prior attempts.

New adult fatality review process

Based on its collaboration with the NC-VDRS, the Division of Aging and Adult Services is **developing an adult fatality case review protocol and data collection process** that will be conducted for every adult in APS who dies.



OHIO Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Ohio Department of Health, Violence & Injury Prevention Program

Collecting data since 2010



ESTABLISHING OHIO'S VIOLENT DEATH REPORTING SYSTEM

NO CENTRALIZED SOURCE FOR CORONER & LAW ENFORCEMENT DATA
- 88 county coroners
- 900+ law enforcement agencies

EDUCATE PARTNERS such as Coroners & Law Enforcement about benefits of a state violent death reporting system & how it works

ESTABLISH ADVISORY BOARD that includes partners who will provide data to – & use data from – the state violent death reporting system

PARTNERSHIPS

PARTNERS CAN ADVOCATE through their professional organizations for the new system

CHALLENGES

EXISTING STATE CONFIDENTIALITY LAWS
- Public Records Law & Open Meeting Acts
- Parts of Coroner reports considered confidential
- Law enforcement records confidential while death under investigation (can take years)

LINKED DATA in the OH-VDRS provide a more **COMPLETE PICTURE** of violent deaths in Ohio

LEGAL COUNSEL & GOVERNMENT AFFAIRS STAFF for the state health department can provide assistance

BENEFITS OF LEGISLATION

EASED CONFIDENTIALITY CONCERNS
- Law supports OH-VDRS when it ***requests*** data
- Law supports coroners & law enforcement when they ***provide*** data

HIGH PARTICIPATION RATES from coroners & law enforcement

LOCAL-LEVEL VIOLENT DEATH DATA AVAILABLE for partners to use in their communities

Ensures data will be used for **VALID PUBLIC HEALTH REPORTING PURPOSES**

OHIO Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Ohio Department of Health, Violence & Injury Prevention Program

Collecting data since 2010



A LEGISLATIVE APPROACH TO ESTABLISHING THE OH-VDRS

To establish the Ohio Violent Death Reporting System (OH-VDRS), the Ohio Department of Health determined that legislation that mandates reporting by key data providers – including coroners and law enforcement agencies – was a necessary first step.

CHALLENGES

Like many states, Ohio has no centralized coroner or law enforcement data systems. Prior to the OH-VDRS, a request for data about a death had to be made to one of 88 county coroners, and at least one of the state's 900+ local law enforcement agencies.

Existing state laws regarding confidentiality presented challenges for establishing the OH-VDRS, including Ohio's Sunshine Laws (Public Records Law & Open Meeting Acts), which allow any person to make a request for information; **law enforcement records** that remain confidential while a death is under investigation (for homicides, this may take years); and **coroner records**, which include investigative notes that may remain confidential, while other coroner data are made public.

PARTNERSHIPS

Partnerships with coroners, medical examiners and law enforcement agencies – and the professional associations representing these partners – were central to the successful passage of the legislation.

To educate partners, the Violence & Injury Prevention Program (VIPP) provided information about the OH-VDRS to coroners, law enforcement and others. Partners supported the OH-VDRS and recommended a legislative approach once they understood how their data would be **kept confidential** and **used for violence prevention efforts** (not typical prior to the OH-VDRS). They also valued being able to **share county-level data from the OH-VDRS with prevention partners in their communities**.

The OH-VDRS Advisory Board included representatives from coroner and law enforcement associations, who spoke on behalf of the OH-VDRS during legislative hearings.

Legal counsel from the Ohio Department of Health helped the VIPP to draft model language. Staff from the department's Office of Government Affairs helped to identify potential legislative paths for the OH-VDRS legislation (e.g. state biennium and mid-biennium budget bills) and respond to requests about the legislation.

LEGISLATION

After multiple attempts over two years, legislation was passed that (1) **established** the OH-VDRS, (2) **authorized** the Ohio Department of Health to study and collect violent death data, (3) **mandated** reporting from key data sources relevant to the OH-VDRS, and (4) deemed all data collected and subsequent work products to be **confidential and exempt from public record requests**.

IMPACT OF LEGISLATION & MANDATED REPORTING

Ohio's legislation requiring confidential, mandated reporting contributed to the credibility and effectiveness of the OH-VDRS. The legislation:

- **supports the OH-VDRS** when it *requests* data from coroners, medical examiners and law enforcement, and **supports coroners and law enforcement** when they *release* data to the OH-VDRS;
- ensures that data collected for the OH-VDRS will be **used for valid public health reporting purposes**; and
- has resulted in **high participation rates** – almost 100% among coroners and about 80% among law enforcement – which in turn help ensure **OH-VDRS's long-term sustainability**.

THE BIG PICTURE

Prior to establishing the OH-VDRS, the Violence & Injury Prevention Program (VIPP) had little data to support its assumptions about different kinds of violent deaths. Now the state has important information about violent deaths. For example:

- In 2010, there were 2,192 violent deaths in Ohio.
- 65%, or nearly two-thirds, of these violent deaths were suicides.
- About 25% of these deaths were homicides.

OH-VDRS data also includes information about the circumstances of violent deaths. With these data, the VIPP has evidence that:

Among women who died from homicide

- 54.2% of these deaths were related to intimate partner violence.

Among persons who died from suicide

- 41.3% were currently depressed,
- 53.1% had a current mental health problem,
- 21.7% had a previous suicide attempt, and 30.8% had disclosed their intent to someone.

54%

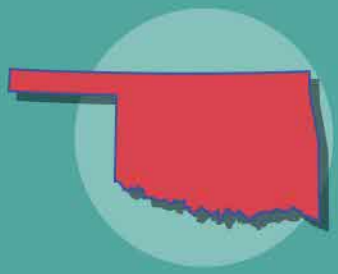
of homicide deaths among women were related to intimate partner violence

OKLAHOMA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Oklahoma State Department of Health, Injury Prevention Service

Collecting data since 2004



DEATH CERTIFICATE

- 47-year-old white male
- Married
- Veteran
- Suicide

MEDICAL EXAMINER

- Had been drinking earlier in the day
- Recent health scare
- History of depression
- Problems at work

LAW ENFORCEMENT

- 9 mm semi-automatic pistol found near the victim
- No suicide note left
- Threatened to kill himself during recent argument with wife as he often did

A SUICIDE IN OKLAHOMA

The example below tells the story of a suicide in Oklahoma, but to ensure confidentiality, it is not the story of an actual death. The example was created to illustrate the violent death data typically collected and linked in the Oklahoma Violent Death Reporting System (OKVDRS).

DEATH CERTIFICATE

The victim was a 47-year-old white male who lived in a rural area of eastern Oklahoma. He was a married oilfield worker with a high school diploma. He died at home due to a single gunshot wound to the head. The manner of death was suicide. The victim was a veteran of the U.S. Armed Forces.

MEDICAL EXAMINER

A 47-year-old white male died from a single gunshot wound to the head. The investigator reports the victim was found in his bedroom after the victim's son heard a shot. The victim was reported to have been drinking earlier that day and had argued with his wife. The victim had recently been having trouble at work due to layoffs. The victim had a previous medical history of depression and had been stressed about a recent health scare. No suicide note was found.

LAW ENFORCEMENT

Law enforcement responded to the home when the victim's son called police after hearing a gunshot and finding his father in the bedroom. The victim's wife reported that she and the victim had argued that morning over finances. She said the victim had threatened to kill himself during the argument, but he often threatened to kill himself when they argued and she didn't think anything of it. She said the victim went to a nearby pond to drink alcohol and shoot guns, but he returned later that afternoon and acted normal. An interview with the victim's son revealed that the victim had seemed stressed lately due to problems at work, concern about losing his job, and a recent diagnosis of cancer with possible related surgery and treatment. There was no suicide note left. A 9mm semi-automatic pistol was found near the victim.

TOXICOLOGY

Toxicology reports showed the victim had a blood alcohol concentration of 0.16.

OKLAHOMA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Oklahoma State Department of Health, Injury Prevention Service

Collecting data since 2004



THE BIG PICTURE

The age-adjusted suicide rate in Oklahoma was 33% higher than the same rate for the U.S. in 2013. Oklahoma Violent Death Reporting System (OKVDRS) data illustrate the extent of this problem.

- Suicide was the third leading cause of death for Oklahomans age 10-34 in 2013, and the most prevalent type of violent death from 2004-2013, accounting for nearly 600 resident deaths each year.
- **Suicides outnumber homicides** by about three to one
- The **Veteran suicide death rate** increased by 34% from 2005-2012, with over 1,000 veteran suicides during that time; the suicide rate among veterans was **twice** that of non-veterans.

Among the 5,881 suicide deaths in Oklahoma from 2004-2013:

- 79% were male, and 21% were female
- 22% of suicide victims were veterans
- 144 (2.4%) victims killed at least one other person before taking his/her own life, **resulting in 173 homicide deaths.**
- **Firearms (61%) were the most prevalent means of suicide,** followed by hanging/strangulation (20%), poisoning (14%), and other means (5%); immediate access to lethal means may increase the risk for suicide.
- Among suicide victims noted to have a diagnosed mental health problem (2,098), **62% were currently receiving mental health treatment.**
- A significant number of suicides were associated with a current depressed mood, intimate partner problem, mental and/or physical health problem, and/or crisis in the past weeks.

22% of the **5,881** suicide deaths from 2004-2013 were **veterans**

TRANSLATING DATA INTO ACTION

Informing prevention planning

- The Oklahoma Injury Prevention Service provides OKVDRS data and statistics and works closely with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), the Oklahoma Suicide Prevention Council, and other suicide prevention groups.
- OKVDRS suicide data informed the Council's 2011 ***Oklahoma Strategy for Suicide Prevention***.

Supporting veteran suicide prevention

With five military bases in Oklahoma, veterans' health issues impact more than 300,000 Oklahomans. **An OKVDRS special study and report on veteran suicides opened doors for collaboration with the Veterans Administration in Oklahoma**, and helped illustrate the:

- increased risk for suicide among veterans of all ages
- leading circumstances associated with veteran suicides across the lifespan – physical and mental health problems, depressed mood, and intimate partner problems
- most common means of suicide (firearms)

Expanding the power of OKVDRS data

- **OKVDRS data will be linked to other state databases** to better inform suicide prevention, mental health treatment, and problematic drug prescriptions related to suicide.
- OKVDRS staff worked with law enforcement, the Child Death Review Board, and the Oklahoma Suicide Prevention Council to modify a pocket card that helps law enforcement collect more complete and accurate suicide circumstances data, which are used to understand suicide risks.



Partnering with law enforcement

- The Oklahoma Association of Chiefs of Police hosts the OKVDRS Advisory Committee meetings and distributes data reports to its members.
- The Oklahoma State Bureau of Investigation maintains a full time program officer to collect law enforcement data for the OKVDRS through a contract with the Injury Prevention Service.

RHODE ISLAND Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Rhode Island Department of Health
Center for Health Data and Analysis and Office of State Medical Examiners

Collecting data since 2004





A SUICIDE IN RHODE ISLAND

The example below tells the story of a suicide in Rhode Island, but to ensure confidentiality, it is not the story of an actual death. The example was created to illustrate the violent death data typically collected and linked in the Rhode Island Violent Death Reporting System (RIVDRS).

DEATH CERTIFICATE

The victim was a 43-year-old white male who lived in a suburb in central Rhode Island. He was a divorced, unemployed machinist. He died at home due to asphyxia from hanging. The manner of death was suicide.

LAW ENFORCEMENT

Law enforcement responded to the victim's home when a neighbor notified law enforcement that when he was returning a tool he borrowed from the victim, he noticed the victim hanging in the victim's garage. While law enforcement were investigating, the victim's ex-wife arrived on scene and stated that a week prior their divorce had been finalized. The victim's wife also stated that she had left him because he stopped going to treatment for his alcoholism. She stated the victim would become violent when he drank and she thinks his drinking also caused him to lose his job. She said he has a history of depression and had been treated for it in the past. She also stated he had no past history of suicide attempts or ideation. A note was found where the victim stated he felt worthless and could not go on without his family.

MEDICAL EXAMINER/ CORONER

The 43-year- old, white male vvictim died from asphyxia due to hanging. He had a tattoo of the Road Runner on his lower left forearm and a tattoo of a knife over his heart. He had ligature marks under and around his neck. The investigator reports the victim was found hanged in his garage where there were numerous empty beer cans scattered around. The victim's friend reports the victim had recently lost his job and recently been divorced.

TOXICOLOGY

Toxicology reports showed the victim had a Blood Alcohol Concentration of .32. There were no other drugs in his system.

MEDICAL RECORDS

The victim had been treated for depression several years earlier and had no history of suicide ideation or attempts.

RHODE ISLAND Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Rhode Island Department of Health, Injury & Violence Prevention Program

Collecting data since 2003



THE BIG PICTURE

In Rhode Island during 2010, there were 165 violent deaths: 135 suicides, 26 homicides and 4 deaths of undetermined manner. The number of suicides in Rhode Island peaked in 2010, declining from 102 suicides in 2011 to 89 in 2012, based on provisional 2012 data.

RIVDRS data for 2004-2010 show that:

- During this seven year period, there were a total of 731 suicides in Rhode Island.
- Males (78%) were far more likely to commit suicide than females (22%).
- Male and female suicide deaths peaked in the age group 45-54 years.
- There were 18 suicides among those aged less than 18 (15 males, 3 females).
- Just over half (52%) of those who died by suicide had a current mental health problem, and 43% were currently receiving mental health treatment.
- Nearly one in five (18%) of those who died by suicide experienced an intimate partner problem.
- 25% of those who died by suicide experienced a crisis in the two weeks prior to death.
- Only 37% of those who died by suicide left a note.

25%

of those who died by suicide experienced a crisis in the two weeks prior to death.

TRANSLATING DATA INTO ACTION

Data from the Rhode Island Violent Death Reporting System (RIVDRS) provided new information on suicide and a better understanding of who is at risk.

- RIVDRS data were used by the Department of Health's Violence & Injury Prevention Program and its prevention partners for **ground-breaking priority setting and program planning**.
- Using new suicide data from the RIVDRS, the Suicide Prevention Subcommittee of the Rhode Island Injury Community Planning Group **identified the adult, working age population as being at increased risk for suicide and suicide attempts**.
- The **data were shared with key partners** through the subcommittee's members, including the State Medical Examiner, RIVDRS Program Manager and Epidemiologist, Violence & Injury Prevention Program manager, and representatives from the Samaritans, American Foundation for Suicide Prevention, community health and mental health centers, Bradley Children's Hospital, Brown University, Coastline Employee Assistance Program, and the Rhode Island Student Assistance Program.
- **An "Economic Impact of Depression and Suicide in the Workplace"** symposium, co-sponsored by the Violence & Injury Prevention Program and Coastline Employee Assistance Program, **increased awareness** of depression and suicide among working age adults and **provided strategies for integrating suicide prevention into worksites**.
- **Symposium participants included high-level managers and human resource representatives from the two largest employers in Rhode Island**.
- **Coastline Employee Assistance Program integrated suicide prevention into its mission statement and now provides training in early identification and referral of at risk employees to their clinical staff as well as their clients.**

RIVDRS data show working age adults are at increased risk for suicide

RIVDRS shares data with suicide prevention partners & 2 of state's largest employers

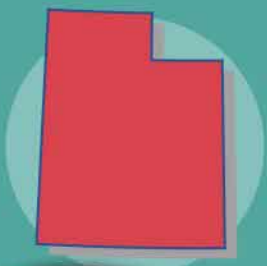
Employee assistance program adds suicide prevention to its mission, refers at-risk employees to clinical staff

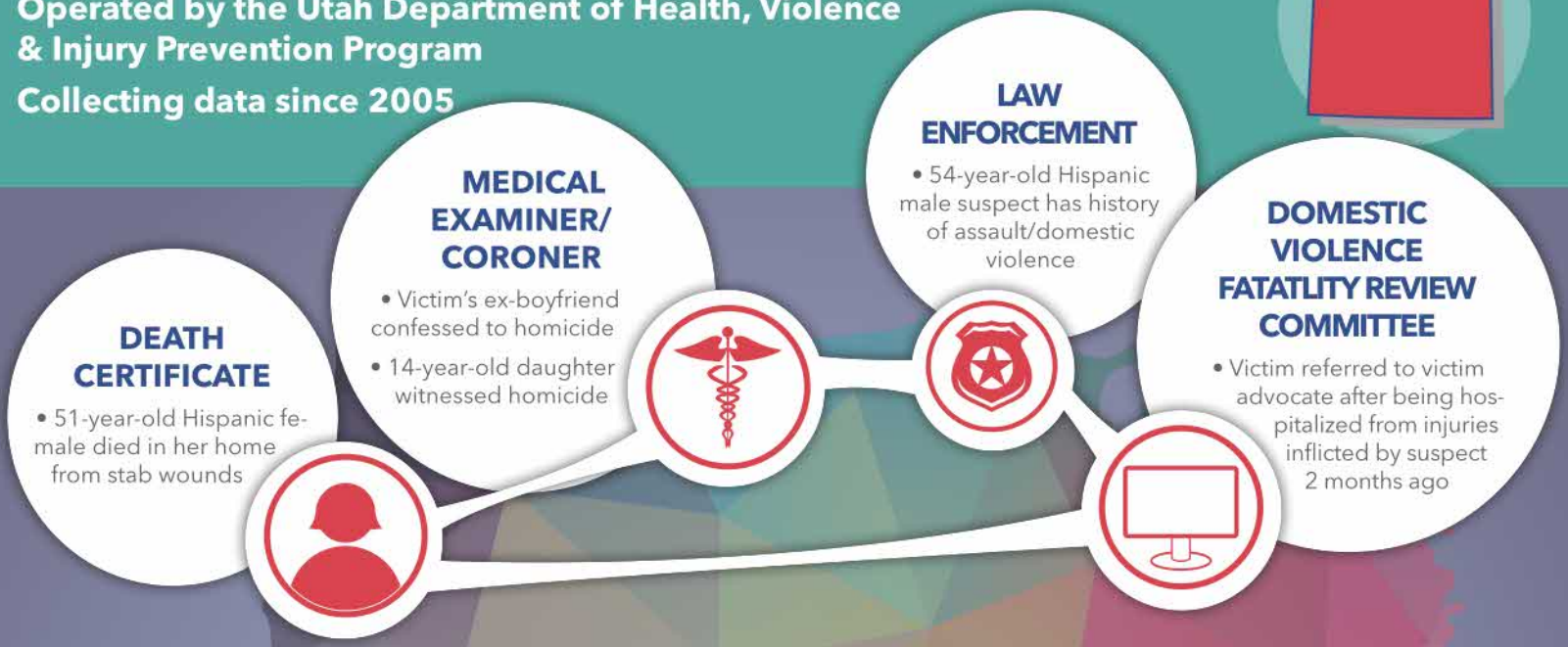
UTAH Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Utah Department of Health, Violence & Injury Prevention Program

Collecting data since 2005





A DOMESTIC VIOLENCE HOMICIDE IN UTAH

The example below tells the story of a suicide in Utah, but to ensure confidentiality, it is not the story of an actual death. The example was created to illustrate the violent death data typically collected and linked in the Utah Violent Death Reporting System (UTVDRS).

DEATH CERTIFICATE



A 51-year-old Hispanic female died at her residence. She was stabbed five times in her abdomen with a large kitchen knife. The manner of death is homicide.

MEDICAL EXAMINER/CORONER



The victim was a 51-year-old Hispanic female who died from five stab wounds to her abdomen. The suspect used a kitchen knife to stab the victim. The death was determined to be a homicide.

Emergency medical services responded to the victim's residence early this morning. The call was made by the 14-year old daughter of the victim and the suspect, a 54-year-old Hispanic male, who is the victim's ex-boyfriend. The suspect confessed to their daughter that he had stabbed the victim.

The 14-year old daughter indicated that the victim was afraid of the suspect and overheard her mother telling a friend that he would kill her one day. The victim was no longer interested in the suspect and was planning on getting married to another man. The victim indicated that this news upset the suspect, but that he just needed time, would soon accept her decision to re-marry, and would then leave her alone.

The victim also had three fractures in her arm and bruises on her back in various stages of healing. Toxicology reports indicate that the victim had no substances present.

LAW ENFORCEMENT



The suspect is a 54-year-old Hispanic male. The victim and suspect were reported as arguing early this morning. Witnesses at the scene indicated they saw the suspect at the victim's home several times in the past few days. Once, the victim and suspect were seen fighting in the yard; the suspect slapped the victim and then immediately left.

The suspect had a long criminal history with several charges relating to assault and domestic violence in the presence of a child. The suspect's criminal history shows an escalation in violence-related charges over the past year. The last incident occurred five weeks prior to the victim's death.

Two months prior, the suspect assaulted the victim, who required hospitalization due to the assault. The suspect confessed to clergy that he had assaulted the victim two months prior.

DOMESTIC VIOLENCE FATALITY REVIEW COMMITTEE



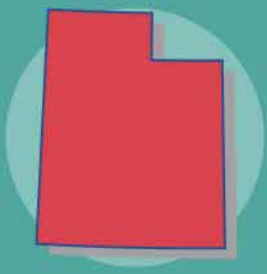
The suspect stalked and harassed the victim. Two months prior to her death, the victim was referred to a victim advocate after she was hospitalized for injuries inflicted by the suspect. The victim was advised to seek domestic violence shelter services. The victim received relocation funds for a new apartment after the assault. For the homicide, the Office of Crime Victim Reparations paid for counseling and mental health services for the 14-year old daughter and for costs of the victim's funeral. The suspect pleaded down from manslaughter (First Degree Felony) to a Second Degree Felony.

UTAH Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Utah Department of Health, Violence & Injury Prevention Program

Collecting data since 2005



THE BIG PICTURE

Domestic violence is one of the fastest growing violent crimes in Utah. Findings from the 2010 publication, *Domestic Violence Fatalities in Utah, 2003-2008*, by the Utah Department of Health's Violence and Injury Prevention Program and the Domestic Violence Fatality Review Committee, include:

- 1 out of 3 adult homicides are domestic violence homicides.
- Females are 10 times more likely than males to die from domestic violence.
- The majority of domestic violence homicides are committed by males.
- While Hispanic persons comprise only 10% of Utah's population, they account for 77% of domestic violence victims.
- 52% of intimate partner homicides were premeditated.
- One-third of domestic violence perpetrators committed suicide after committing a homicide.
- 91% of the domestic violence-related suicide victims experienced a crisis prior to the incident or faced an impending crisis – the most common of which was facing a criminal legal problem such as a recent or impending arrest, police pursuit, or an impending criminal court date (32.7%).

78%

of the **147** children directly exposed to a homicide in 2003-2008 were age **5 or younger**

- In 44% of intimate partner violence incidents, one or more children under age 18 were living at the victim's home at the time of the incident (76 children total).
- 147 children under age 18 were directly exposed to the homicide – they saw it, heard it through the walls, were attacked or threatened during the incident, or discovered the body. Of these children, 78% were 5 years old or younger.

TRANSLATING DATA INTO ACTION

Better data provide more complete picture of domestic violence deaths

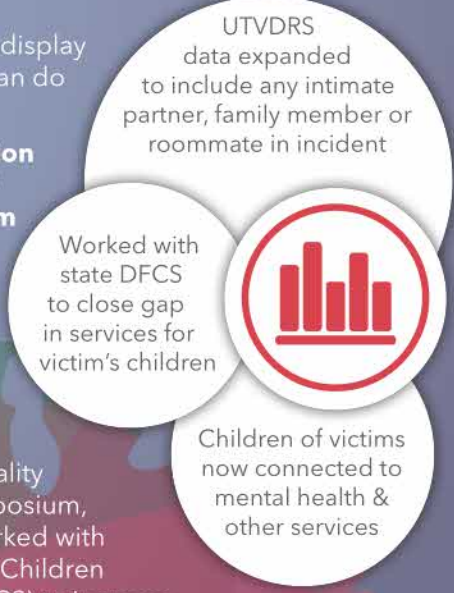
A decade ago, it was difficult to know the extent of domestic violence in Utah because of limited data. The Utah Violent Death Reporting System (UTVDRS) has developed a more complete picture of domestic violence and its tragic impact on men, women, and children by:

- fostering a strong partnership between the Utah Department of Health's Violence and Injury Prevention Program (VIPP) and the state's multi-disciplinary Domestic Violence Fatality Review Committee (DVFRC), which includes more than 9 agencies,
- **expanding domestic violence data collection beyond the victim and suspect to include any intimate partner, family member and/or roommate involved in the incident,**
- **combining national and state-specific intimate partner violence variables** to enable the UTVDRS to collect more – and more detailed – domestic violence-related data, and
- linking data in the UTVDRS to identify and review – for the first time – when a domestic violence suspect committed suicide after the homicide.

Linking children of victims to needed services

Intimate partner violence is particularly damaging to children who witness this violence. They are at greater risk of developing psychiatric disorders, developmental problems, school failure, violence against others, and low self-esteem, and younger children typically display higher levels of distress than do older children.

Through their collaboration on the UTVDRS, the VIPP and DVFRC helped inform a policy change to close a gap in services for the children of domestic violence-related homicide victims.



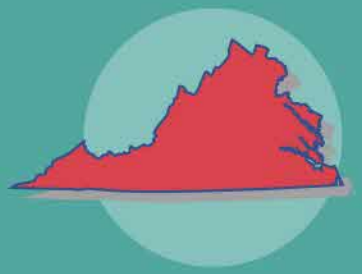
- Following recommendations from a Domestic Violence Fatality Recommendations Symposium, the VIPP and DVFRC worked with the state Department of Children and Family Services (DFCS) to increase immediate referrals to DFCS at the time of a homicide – usually by law enforcement investigating the death – if the victim or perpetrator has one or more children in the home, regardless if a child was present during the incident.
- These **referrals enabled these children and their families to receive an assessment and get connected to intervention and follow-up services**, such as mental health services, to help cope with the homicide and other domestic violence-related issues.
- A referral to DFCS was made in 13 (46%) of the 28 intimate partner violence incidents with children in the home during 2003-2008.

VIRGINIA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Virginia Department of Health, Office of the Chief Medical Examiner

Collecting data since 2003



DEATH CERTIFICATE
- 82-year-old white male
- Widowed veteran
- Suicide

MEDICAL EXAMINER
- Suffering from lung cancer
- Had stopped chemotherapy
- Taking pain medication

LAW ENFORCEMENT
- 2 bottles of prescription pain meds on counter
- Suicide note left by victim
- Victim's daughter said her father would kill himself if cancer got bad again

A SUICIDE IN VIRGINIA

The example below tells the story of a suicide in Virginia, but to ensure confidentiality, it is not the story of an actual death. The example was created to illustrate the violent death data typically collected and linked in the Virginia Violent Death Reporting System (VVDRS).

DEATH CERTIFICATE

The victim was an 82-year-old white man who lived in a small rural community in Southwest Virginia. He was a U.S. citizen born in North Carolina. He was a widowed veteran and a retired truck driver for a regional supermarket chain. He died at home from a gunshot wound to the head. The manner of death was suicide.

MEDICAL EXAMINER/ CORONER

The victim died from a gunshot wound to the head. Entrance and exit wounds reveal a single intra-oral shot using a revolver. Other pathological diagnosis included lesions on his right lung and a history of surgical removal of the lower lobe of the left lung. The victim had a tattoo with a U.S. Navy 1949-1951 anchor on his right forearm. Bruising on his forehead at autopsy suggested that he had fallen and hit his head near the time of his death. Medical records revealed that he was suffering from lung cancer, had stopped receiving chemotherapy, and was recently referred to a pain management specialist because he was frustrated with his level of pain. Pill counts revealed he had taken one dose of Oxymorphone and one of Percocet.

LAW ENFORCEMENT

Law enforcement was called to the victim's home when a neighbor reported that she had not seen him for a few days. His car was in the driveway. Law enforcement responded for a welfare check and discovered a mildly decomposed body on the living room floor of the home with a revolver lying near the right side of his body. The home was locked and secure. Law enforcement described the home as clean and neat with no evidence of foul play or intrusion. Notes on a nearby table provided post-mortem instructions on bills and funeral arrangements and a copy of his will. Two bottles of prescription medicine, one for Oxymorphone and one for Percocet, were found on the kitchen counter. Law enforcement interviewed the victim's daughter who reported that her father had been diagnosed with a recurrence of lung cancer five months ago and complained about significant pain. He had told family and friends repeatedly that if his cancer ever got bad again, he would just end it. The daughter reported that her father had no history of mental health problems and that he did not like to take pain medications because it made him sleepy and caused him to lose his balance.

TOXICOLOGY

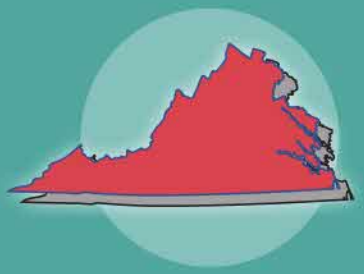
Toxicology studies revealed that the victim did not have any opiates in his blood, but did have a Blood Alcohol Concentration of .028. Medical records showed that he had gone to a pain specialist who prescribed Oxymorphone and Percocet.

VIRGINIA Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Virginia Department of Health, Office of the Chief Medical Examiner

Collecting data since 2003



THE BIG PICTURE

Elder suicide is a complex social problem that is often overshadowed by a focus on suicide among youth, college students or veterans. Data from the Virginia Violent Death Reporting System (VVDRS) show that:

- **elders have a higher suicide risk** (rate of 15.6) than non-elders (rate of 10.7);
- elder men are 6 times more likely than elder women to die from suicide, and **as elder men age, their suicide rate increases while it decreases for elder women;** and
- elder and non-elder suicides **differ notably in the circumstances and life events that lead to suicide,** including the presence of mental and physical health problems.

Suicide rates **increase** for elder men as they age, but **decrease** for elder women

TRANSLATING DATA INTO ACTION

A new picture of elder suicide

Combining data sources through the VVDRS enabled the Virginia Department of Health to:

- develop a **new and more complete picture of elder suicide** by exploring it as a separate and unique phenomenon;
- **identify what makes elder suicide fundamentally different** from non-elder suicide – including life altering events such as a change in marital status, onset of illness, loss of capacity for independent living, and mental and physical health problems;
- **make recommendations for where to target prevention efforts,** particularly among older men; and
- conclude, in its report *Elder Suicide in Virginia: 2003-2010*, that **elder suicide is an issue that can only be addressed by treating it as distinct from non-elder suicide.**

Regional summits increase resources

- Spurred by the release of the VVDRS data, the Virginia Department of Behavioral Health and Developmental Services – a key partner and VVDRS Advisory Committee member – funded **7 regional suicide summits** to bring together mental health, public health and other violence prevention advocates for a day of suicide prevention planning.
- In each region, Department of Health staff used VVDRS data to give a tailored data presentation on suicide. Summit participants then looked at state and local resources and **developed a regional suicide prevention plan** to address at-risk populations and the specific circumstances associated with suicide in their communities.
- Based on VVDRS data and the momentum generated by the regional summits, the Virginia Department of Behavioral Health and Developmental Services requested and **received funding for a state suicide prevention coordinator to address suicide issues across the lifespan**.

VVDRS data show elder suicide is fundamentally different from non-elder suicide

Regional suicide prevention plans developed via 7 summits

State suicide prevention coordinator hired by state mental health agency

Educating through data

- In response to frequent media and community-level requests for data, VVDRS staff have provided data, radio and newspaper interviews, and **education around the fact that suicide is more common than homicide in Virginia** – a fact that often surprises those requesting the data.
- Since the VVDRS began publishing its data, staff has seen **a jump in requests** – from about 3 to 30 per year.
- With the VVDRS, the Department of Health can respond with more robust, useful and finely-tuned information – including the circumstances, methods of fatal injury, and risk factors related to violent deaths that **enable communities to hone in on specific local issues and inform the work of their prevention specialists.**
- **Specialized VVDRS reports** on the circumstances of a particular type of violent death – such as who dies at work and the issue of suicide among military members – have garnered extensive interest from the media, data users and stakeholders.

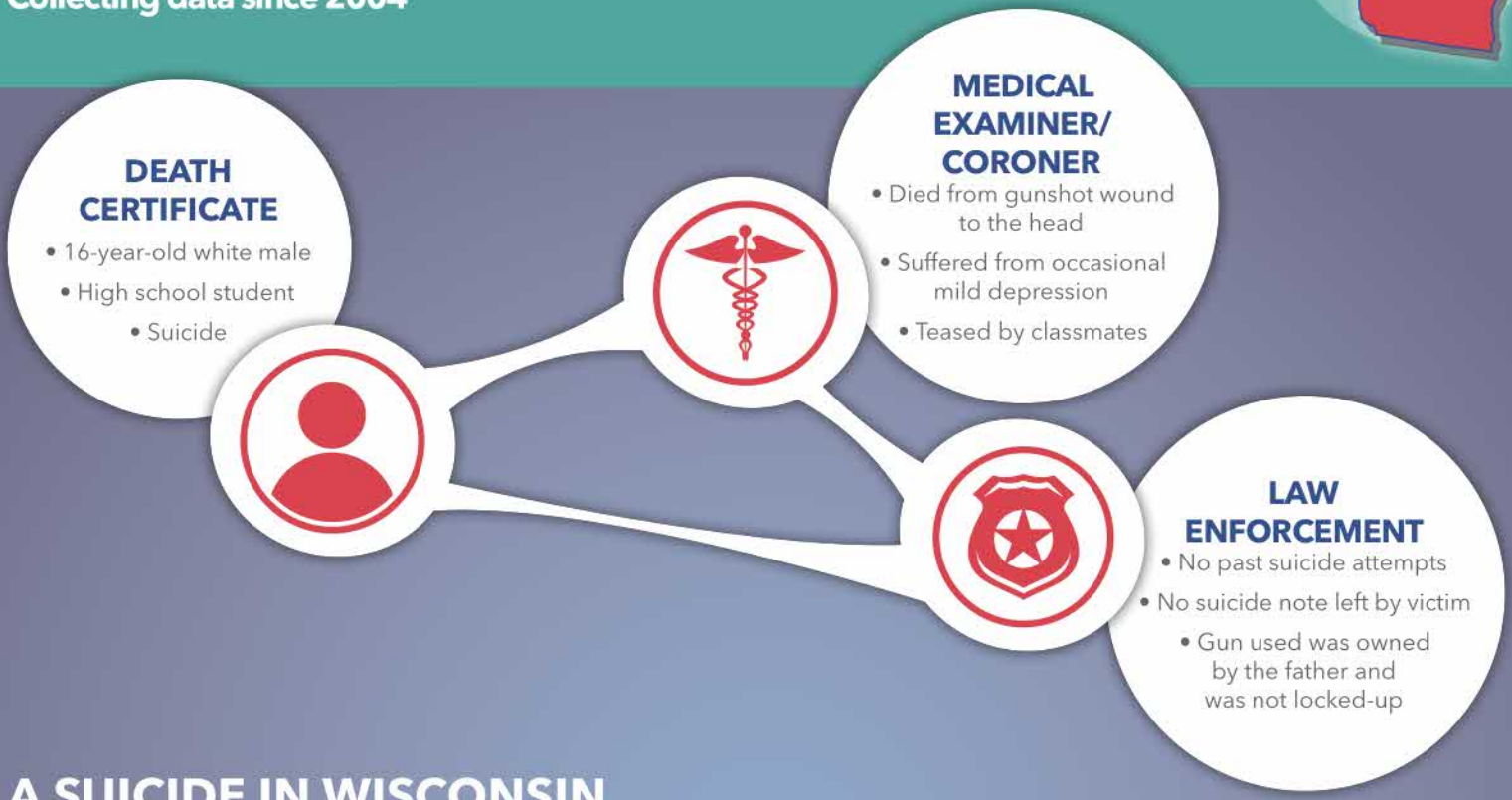
WISCONSIN Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Wisconsin Department of Health Services, Injury and Violence Prevention Program

Collecting data since 2004





A SUICIDE IN WISCONSIN

To ensure confidentiality, this is not an actual suicide but the profile of a suicide in Wisconsin. The example was created to illustrate the type of violent death data collected and linked in the Wisconsin Violent Death Reporting System (WVDRS).

DEATH CERTIFICATE

The victim was a 16-year-old white male who lived in rural northern Wisconsin. He was a high school student. He died at his residence due to a gunshot wound to the head. The manner of death was suicide.

MEDICAL EXAMINER/ CORONER

The 16-year-old white male victim died from a self-inflicted gunshot wound to the head. The victim's parents stated that he suffered from mild depression but only occasionally saw a therapist, since she was 30 miles away. They stated he did not have a lot of friends, and one day in the past week he came home from school very upset after being teased by a few classmates for being overweight.

LAW ENFORCEMENT

The victim told his parents he was going for a walk in the evening. About 15 minutes later, they heard the sound of a gunshot nearby. They went outside and found their son in a wooded area in their backyard with a gunshot wound to the head. Law enforcement responded upon receiving a call from the parents. The victim was pronounced dead at the scene. The father stated that the gun that was used belonged to him; he kept it hidden (not locked) in the basement. There was no suicide note found, and the parents stated he had not had any past suicidal attempts or ideations.

TOXICOLOGY

There were no drugs or alcohol found in the victim's system.

WISCONSIN Violent Death Reporting System

Part of CDC's National Violent Death Reporting System

Operated by the Wisconsin Department of Health Services, Injury and Violence Prevention Program

Collecting data since 2004



THE BIG PICTURE

The Wisconsin Violent Death Reporting System (WVDRS) has provided a better understanding of who is dying, how they are dying, and the circumstances that may be associated with those violent deaths.

- Among the **249 youth under age 18 who died from suicide** during 2004-2013:
  - 186 (75%) were **male**
  - 103 (41.4%) of the deaths were **committed with a firearm;** among these cases, the **firearm owner was the child's parent** in at least 40 cases (38.8%) and the **firearm was stored unlocked** in at least 22 cases (21.4%)
- Among the 228 (91.6%) youth suicides where circumstances surrounding the death were known by either the coroner/ medical examiner or law enforcement:
  - 97 (42.5%) had **a current mental health problem** and 104 (45.6%) **currently or in the past had treatment for mental illness**
  - 119 (52.2%) **experienced a crisis** in the preceding two weeks (compared to 37.2% of adult suicides)
  - 70 (30.7%) were **experiencing problems at or related to school**
- The highest age-adjusted death rates for youth suicides tend to be in **more rural counties,** yet Wisconsin's western and northern rural counties **have the lowest number of mental health providers per capita.**
- Groups at higher risk for suicide in Wisconsin include **youth in more rural counties, American Indians/Alaska Natives, LGBT persons, and veterans.**
- Whites have the highest suicide rate overall, but **non-white students were more likely to report attempting, planning or considering suicide in the past 12 months.**

41%
of youth suicide deaths were committed with a firearm

TRANSLATING DATA INTO ACTION

Informing prevention

- WVDRS data were used to develop and inform content of the ***2015 Wisconsin Suicide Prevention Strategy***, and local-level WVDRS data can **help local coalitions identify how best to target their suicide prevention efforts**.
- Wisconsin's WVDRS and Maternal Child Health (MCH) program **partnered with Mental Health America of Wisconsin** to support and advise local health departments in Wisconsin on best practices for adolescent suicide prevention, including coalition development, QPR gatekeeper training, Zero Suicide, and means reduction.

Improving access to and quality of mental health services

WVDRS data helped inform the **Wisconsin School Mental Health Project**, a five-year project launched in 2015 in over 25 school districts that includes youth suicide prevention. The project reflects efforts of Wisconsin's mental health, public health, and education agencies and advocates to **reduce perceived stigma** attached to mental illness and accessing mental health services; **train school-community teams**; and **increase the number of adults who recognize the signs of youth who are having trouble** and know how to approach students and their families to access appropriate services.

Addressing the *how* in suicide

How persons attempt suicide plays a key role in whether they live or die. **"Means reduction" – reducing a suicidal person's access to highly lethal means such as firearms – is recognized as an evidence-based practice** that is an important part of a comprehensive approach to suicide prevention.

- The ***2015 Wisconsin Suicide Prevention Strategy*** includes an objective to create suicide-safe environments for people at risk of suicide through strategies such as means reduction.
- The best-practice program ***CALM: Counseling on Access to Lethal Means*** trains providers to implement counseling strategies to help clients at risk for suicide and their families reduce access to lethal means, particularly (but not exclusively) firearms.
- **County-level suicide prevention** efforts have included offering cable gun locks and providing firearm safety and means restriction/reduction education. Acknowledging that most teens know where their parents keep their guns, messages include storing guns that are locked, unloaded and with ammunition locked and stored separately.

WVDRS data informed the Wisconsin School Mental Health Project

Local-level data helps coalitions target suicide prevention efforts

Creating suicide-safe environments through means reduction is part of the WI prevention strategy

ACKNOWLEDGEMENTS
NVDRS: STORIES FROM THE FRONTLINES OF VIOLENT DEATH SURVEILLANCE

Safe States Alliances thanks the individuals who contributed to ***NVDRS: Stories from the Frontlines of Violent Death Surveillance.***

State health department staff from the states below contributed their time to gather and share information, data and their experiences with the NVDRS and their state violent death reporting systems. Their efforts made this document possible.

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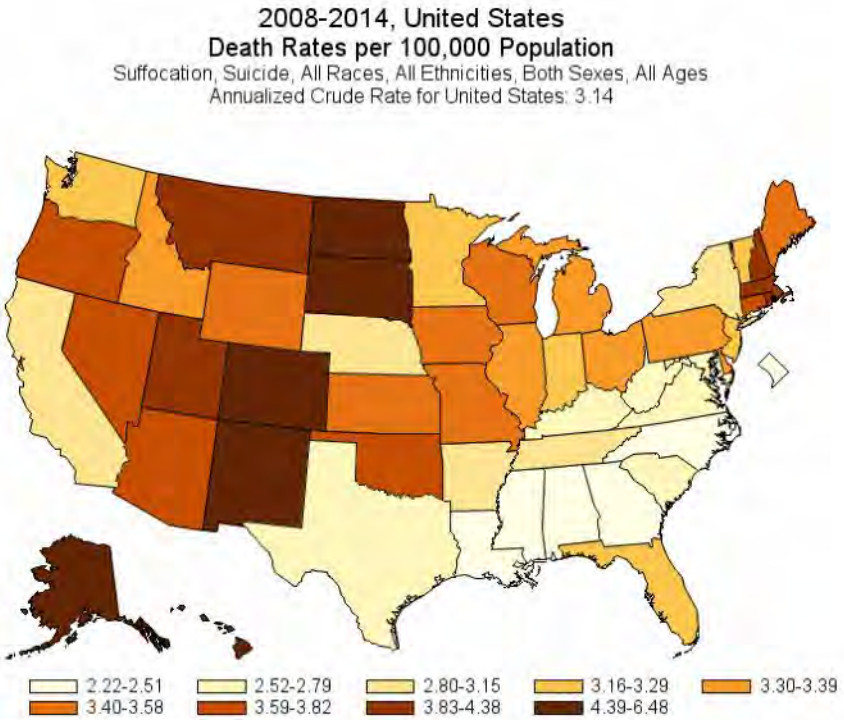
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www.dhs.wisconsin.gov/wish/violent-death/nvdrs.htm

Kristen Lindemer of Safe States Alliance compiled and edited the document. Graphic design and layout by Melba Searcy, Creative Director, Toasted Ink (Atlanta). Layout updates in 2015 by Julie Alonso, Safe States Alliance.

EXAMPLES OF SUICIDE DATA AVAILABLE FROM CDC'S WEB SITE

https://www.cdc.gov/injury/wisqars/fatal.html

EXAMPLE ONE: MAP OF SUICIDE RATES

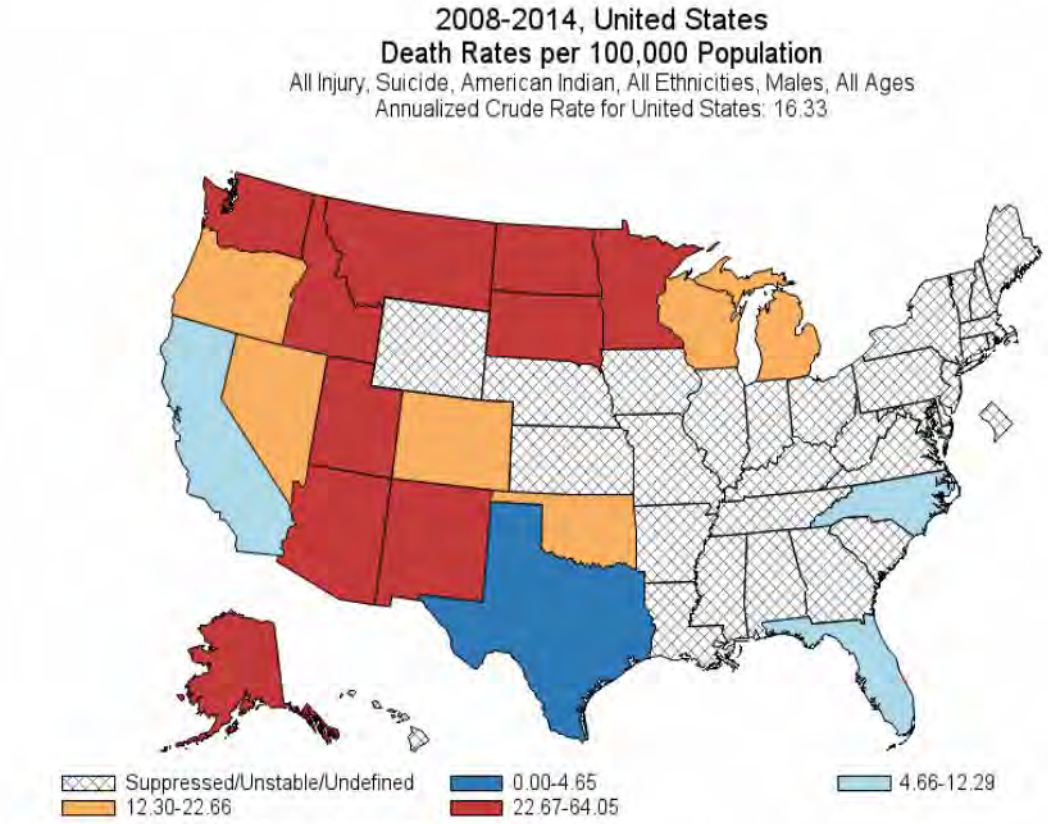


Reports for All Ages include those of unknown age.

* Rates based on 20 or fewer deaths may be unstable. States with these rates are cross-hatched in the map (see legend above). Such rates have an asterisk.

Produced by: the Statistics, Programming & Economics Branch, National Center for Injury Prevention & Control, CDC
Data Sources: NCHS National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates.

EXAMPLE TWO: MAP OF SUICIDE RATES, AI/AN MALES



Produced by: the Statistics, Programming & Economics Branch, National Center for Injury Prevention & Control, CDC
Data Sources: NCHS National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates

EXAMPLE THREE: CIRCUMSTANCES OF SUICIDE DEATHS, HISPANIC, FEMALES, STATE OF COLORADO

2014, NVVVS StVtes: CO

VeVth Counts by CircumstVnces of VeVth

Suicide CircumstVnces, AVV MechVnisms

AVV VVces, HispVnic, FemVVes, AVV Ages

House/VpVrtment/yVrd/drivewVy, VesidentiVV institution/sheVter/prison, HighwVy/street/roVd/VutomobiVe, VecreVtionVV/cuVturVV VreV/pubVic buiVding, CommerciVV/fVrm/industriVV/construction VreV, NVturVV VreV/countryside/forest, Other incVuding schooV/sports VreVs

Circumstance	Death Counts	Percentage
Total number of victims	24	100.00
All victims with unknown circumstances	--*	--*
All victims with known circumstances	21	87.50
Current Depressed Mood	11	52.38
Current Mental Health Problem	11	52.38
Current treatment for mental illness	9	42.86
Ever Treated for Mental Problem	12	57.14
Person left a suicide note	7	33.33
Disclosed intent to commit suicide	5	23.81
History of Suicide Attempts	10	47.62
Crisis in past 2 weeks	7	33.33
Intimate partner problem	13	61.90
Eviction or loss of home **	0	0.00
Other relationship problem	1	4.76
Physical health problem	7	33.33
Alcohol Dependence	8	38.10
Other Substance Problem	3	14.29
Recent criminal legal problem	3	14.29
Other legal problems	0	0.00
Job problem	0	0.00
Financial problem	1	4.76
School problem	2	9.52
Suicide of friend or family in past five years	2	9.52
Other death of friend or family	3	14.29
Other suicide circumstance	0	0.00
Other undetermined circumstance	0	0.00

Reports for All Ages include those of unknown age. Manner of death reported here is assigned by the state abstractor based on all available standard NVDRS data sources.

Note1: Victims can have one or more circumstances; therefore, subcategories may not sum to all known circumstances.

Note2: Percentages for specific known circumstance categories were computed using the count of 'All victims with known circumstances' as the denominator.

Data Sources: National Violent Death Reporting System (NVDRS) for Number of Deaths, Bureau of Census for Population Estimates.

Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC

--* The number of deaths fewer than 10; the number has been suppressed to retain confidentiality.

** The circumstance 'eviction or loss of home' was added to NVDRS in 2010. Counts for this variable prior to 2010 are considered unreliable.

EXAMPLE FOUR: COST OF SUICIDE, MALES, WESTERN REGION

Fatal Injuries, Male, All Ages , West, 2010

Intent: Suicide

Mechanism: All

Number of Deaths and Estimated Average and Total Lifetime Costs

Classified by Mechanism and Intent

Costs Expressed in 2010 Regional Prices

Deaths and Type of Cost			Intent
			Suicide
Mechanism			
All Mechanisms	Deaths	--	7,755
	Medical Cost	Average	$3,546
		Total	$27,497,000
	Work Loss Cost	Average	$1,203,764
		Total	$9,335,186,000
	Combined Cost	Average	$1,207,309
		Total	$9,362,683,000

Injury Classification Scheme: Mechanism by Intent of Injury.

Reports for All Ages include those of unknown age.

Total cost estimates are additive within the region.

* Cost estimates based on 20 or fewer deaths are considered unstable. Estimates based on more than 20 deaths may also be unstable due to high relative variability of case-level costs. Interpret unstable estimates with caution.

Note: For injury-related deaths, lifetime medical costs refer to the medical costs associated with the fatal injury event.

Produced by: National Center for Injury Prevention and Control, CDC

Data Source: NCHS Vital Statistics System for numbers of deaths. NEISS All Injury Program operated by the U.S. Consumer Product Safety Commission (CPSC) for numbers of nonfatal injuries. Pacific Institute for Research and Evaluation (PIRE), Calverton, MD for unit cost estimates.

EXAMPLE FIVE: YEARS OF POTENTIAL LIFE LOST

Years of Potential Life Lost (YPLL) Before Age 65

2016 United States
All Races, Both Sexes
All Deaths

Cause of Death	YPLL	Percent
All Causes	11,928,107	100.0%
Unintentional Injury	**2,739,490**	**23.0%**
Malignant Neoplasms	1,715,904	14.4%
Heart Disease	1,349,164	11.3%
Suicide	**895,466**	**7.5%**
Perinatal Period	745,134	6.2%
Homicide	**607,886**	**5.1%**
Congenital Anomalies	421,944	3.5%
Liver Disease	301,329	2.5%
Diabetes Mellitus	252,804	2.1%
Cerebrovascular	228,104	1.9%
All Others	2,670,882	22.4%

Download Results in a Spreadsheet (CSV) File

Terms for Causes of Death

Help with Download

Produced By: National Center for Injury Prevention and Control, CDC
Data Source: National Center for Health Statistics (NCHS) Vital Statistics System.

From: Coleman, Akeiisa
Sent: 20 Jun 2018 21:02:50 +0000
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Black, Erin (CDC/ONDIEH/NCIPC);Dennehy, Heather (CDC/ONDIEH/NCIPC);Wilkniss, Sandra
Subject: RE: June 22 webinar - CDC introduction slides

Thanks Deb!
Akeiisa Coleman, MSW
Senior Policy Analyst, Health Division
National Governors Association
202.624.5344 | acoleman@nga.org

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 4:58 PM
To: Coleman, Akeiisa ; Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Black, Erin (CDC/ONDIEH/NCIPC) ; Dennehy, Heather (CDC/ONDIEH/NCIPC) ; Wilkniss, Sandra
Subject: RE: June 22 webinar - CDC introduction slides

Here are my slides as well! Thanks!
Deb

From: Coleman, Akeiisa <AColeman@NGA.ORG>
Sent: Wednesday, June 20, 2018 4:42 PM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Wilkniss, Sandra <SWilkniss@NGA.ORG>
Subject: RE: June 22 webinar - CDC introduction slides

Thanks Alex!
Akeiisa Coleman, MSW
Senior Policy Analyst, Health Division
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202.624.5344 | acoleman@nga.org

From: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Sent: Wednesday, June 20, 2018 4:39 PM
To: Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Wilkniss, Sandra <SWilkniss@NGA.ORG>
Subject: RE: June 22 webinar - CDC introduction slides

Greetings:
I have attached the slides.
Alex C

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Friday, June 15, 2018 11:25 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Coleman, Akeiisa <AColeman@NGA.ORG>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar

Wonderful!

On Jun 15, 2018, at 9:27 AM, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov> wrote:

> Greetings:
> It looks like I am available on the 22nd for the webinar & on Weds, 20th for the pre-brief.
> Alex C
>
> ---
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Date:** June 15, 2018 at 6:45:31 AM EDT
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Coleman, Akeiisa <AColeman@NGA.ORG>, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>, Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>, Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
> **Subject:** Re: June 22 webinar
> Great. Will send and invitation for Wednesday at 3:30-4. I could talk later in the day on Monday if you want to do it sooner, but am stuck before noon. thanks!
> Sandra
>
> ---
>
> **From:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Sent:** Thursday, June 14, 2018 11:34:07 PM
> **To:** Wilkniss, Sandra
> **Cc:** Coleman, Akeiisa; Crosby, Alexander (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Dennehy, Heather (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC)
> **Subject:** RE: June 22 webinar
> Yes, it would be helpful if you could schedule a pre-brief next week. From a quick peek at calendars it looks like Alex, Deb and myself might be available Monday 10:30-11 or Wed 3:30-4.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 14, 2018 11:25 PM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Coleman, Akeiisa <AColeman@NGA.ORG>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
> **Subject:** Re: June 22 webinar
> Hello Erin and Dr Stone.
> We can be flexible in the federal overview and take your lead on the data to highlight as well as any priority strategies, federal-state partnership aimed at preventing suicide you would like to share. May we schedule a call with the three of you for when Alex returns early next week to plan? Thank you!

Sandra

On Jun 14, 2018, at 11:19 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Ladies – what does the federal overview in the agenda below consist of? As mentioned I plan to be on the call, also the Vital Signs lead author, Deb Stone (copied), will be on the call to present on the Vital Signs. Alex is currently on leave but back next week to discuss his availability.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 14, 2018 1:25 PM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Coleman, Akeiisa <AColeman@NGA.ORG>
> **Subject:** June 22 webinar
>
> Hi again, Erin. We just discussed the layout for this webinar and wanted to bullet it out for you for discussion you are having at CDC:
> Call is June 22 from 2 – 3pm eastern with governors health policy adivisors (all states and territories invited)
> 5 minutes flex time for people to get on the call and announce themselves
> 10 min federal overview
> 2 min overview of what to expect – NGA
> 5-7 min CDC talking about recent data
> 5-7 min NGA to summarize meeting highlights
> 5-7 min state rep from CO to talk about their comprehensive approach
> 5-7 min ID/UT rep to talk about prevention or partnership (this is being nailed down in the next couple days)
> 15 min Q & A
> We will be able to show slides.
> I hope this helps!
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 14, 2018 10:50 AM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
>
> HI Erin,
> It is still being reviewed internally. So, we had hoped to do the webinar after the paper was done. However, the opportunity on the 22nd came up and we thought it more important to capitalize on the momentum of your recent report rather than wait for our paper to be final. We think it critical to get attention to the issue while its top of mind. Sound ok?
>
> **From:** Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
> **Sent:** Thursday, June 14, 2018 10:25 AM
> **To:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
>
> Have you sent us a copy of the report yet from the convening that you will be discussing on the call? I will be on the call but also still confirming if others will attend. Alex is out until Monday.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 9:49 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: Re: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin -

We have all things ready to go for the webinar next Friday. Are you ok to cover the new data and/or can others join the call? We are super excited to highlight and get the info to all governors. Thanks!

On Jun 12, 2018, at 1:30 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Sandra – I am available that day/time – but let me check internally and see who would be best to present on the VS and get back to you.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Tuesday, June 12, 2018 9:00 AM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
>
> Good morning Erin, Alex, Malia and Heather,
> Thanks again for this terrific report! We are updating the paper now with new stats. In the meantime, we have had an opening for our state leadership calls for June 22 2-3pm eastern which we could use to highlight the findings of the Vital Signs report and lessons learned from our meeting and we have a couple of states available to give brief comments about their strategies. I am hoping that it is possible for you all to be available that day/time for the webinar with governors health policy advisors? It is usually very well attended and may help perpetuate the momentum around your report. Please let me know if it's possible and we can jump on a call and sort out details. Thanks!
> Sandra
>
> **From:** Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
> **Sent:** Thursday, June 7, 2018 1:34 PM
> **To:** Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
> **Cc:** Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs,

Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

I will be on leave July 16-20 and in an all-day meeting July 31.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 7, 2018 1:27 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hello Erin and Team. Congratulations! We can't wait to review and will incorporate into the white paper and will share with our folks. The date for the webinar has not yet but set, but we are looking at July. Would it be possible for you to let us know of dates that do not work in July for at least one of your team to join and share the Vital Signs highlights? Thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 9:56 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Sandra and Akeiisa,

As we mentioned, our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* will be released later today. The report includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions.

The CDC celebrates the National Governors Association's commitment to creating safe communities. We hope that this resource can provide state leaders with an increased understanding of the impact of suicide in their states, as well as potential solutions for prevention.

I would appreciate it if you could help disseminate the Vital Signs to your networks once the embargo lifts at 1:00 pm. Also, as discussed we will plan to highlight the Vital Signs on the

planned Webinar with State health policy advisors (has a date been set yet?).
Erin

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join

us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

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review, dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify the sender and delete this message.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 20 Jun 2018 20:57:30 +0000
To: Coleman, Akeiisa;Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Black, Erin (CDC/ONDIEH/NCIPC);Dennehy, Heather (CDC/ONDIEH/NCIPC);Wilkniss, Sandra
Subject: RE: June 22 webinar - CDC introduction slides
Attachments: Vital Signs NGA Meeting 6.22.18_clean.pptx

Here are my slides as well! Thanks!
Deb

From: Coleman, Akeiisa
Sent: Wednesday, June 20, 2018 4:42 PM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Black, Erin (CDC/ONDIEH/NCIPC) ; Dennehy, Heather (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Wilkniss, Sandra
Subject: RE: June 22 webinar - CDC introduction slides

Thanks Alex!
Akeiisa Coleman, MSW
Senior Policy Analyst, Health Division
National Governors Association
202.624.5344 | acoleman@nga.org

From: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Sent: Wednesday, June 20, 2018 4:39 PM
To: Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Wilkniss, Sandra <SWilkniss@NGA.ORG>
Subject: RE: June 22 webinar - CDC introduction slides

Greetings:
I have attached the slides.
Alex C

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Friday, June 15, 2018 11:25 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Coleman, Akeiisa <AColeman@NGA.ORG>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar

Wonderful!

On Jun 15, 2018, at 9:27 AM, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov> wrote:

> Greetings:
> It looks like I am available on the 22nd for the webinar & on Weds, 20th for the pre-brief.
> Alex C

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Date: June 15, 2018 at 6:45:31 AM EDT
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Coleman, Akeiisa <AColeman@NGA.ORG>, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>, Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>, Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar

Great. Will send and invitation for Wednesday at 3:30-4. I could talk later in the day on Monday if you want to do it sooner, but am stuck before noon. thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Sent: Thursday, June 14, 2018 11:34:07 PM
To: Wilkniss, Sandra
Cc: Coleman, Akeiisa; Crosby, Alexander (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Dennehy, Heather (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar

Yes, it would be helpful if you could schedule a pre-brief next week. From a quick peek at calendars it looks like Alex, Deb and myself might be available Monday 10:30-11 or Wed 3:30-4.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 11:25 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Coleman, Akeiisa <AColeman@NGA.ORG>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar

Hello Erin and Dr Stone.
We can be flexible in the federal overview and take your lead on the data to highlight as well as any priority strategies, federal-state partnership aimed at preventing suicide you would like to share. May we schedule a call with the three of you for when Alex returns early next week to plan? Thank you!
Sandra

On Jun 14, 2018, at 11:19 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Ladies – what does the federal overview in the agenda below consist of? As mentioned I plan to be on the call, also the Vital Signs lead author, Deb Stone (copied), will be on the call to present on the Vital Signs. Alex is currently on leave but back next week to discuss his availability.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 14, 2018 1:25 PM

To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Coleman, Akeiisa <AColeman@NGA.ORG>
Subject: June 22 webinar

Hi again, Erin. We just discussed the layout for this webinar and wanted to bullet it out for you for discussion you are having at CDC:
Call is June 22 from 2 – 3pm eastern with governors health policy adivisors (all states and territories invited)
5 minutes flex time for people to get on the call and announce themselves
10 min federal overview
2 min overview of what to expect – NGA
5-7 min CDC talking about recent data
5-7 min NGA to summarize meeting highlights
5-7 min state rep from CO to talk about their comprehensive approach
5-7 min ID/UT rep to talk about prevention or partnership (this is being nailed down in the next couple days)
15 min Q & A
We will be able to show slides.
I hope this helps!

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 10:50 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

HI Erin,
It is still being reviewed internally. So, we had hoped to do the webinar after the paper was done. However, the opportunity on the 22nd came up and we thought it more important to capitalize on the momentum of your recent report rather than wait for our paper to be final. We think it critical to get attention to the issue while its top of mind. Sound ok?

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 14, 2018 10:25 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Have you sent us a copy of the report yet from the convening that you will be discussing on the call? I will be on the call but also still confirming if others will attend. Alex is out until Monday.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 9:49 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: Re: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin -
We have all things ready to go for the webinar next Friday. Are you ok to cover the new data and/or can others join the call? We are super excited to highlight and get the info to all governors. Thanks!

On Jun 12, 2018, at 1:30 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Sandra – I am available that day/time – but let me check internally and see who would be best to present on the VS and get back to you.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Tuesday, June 12, 2018 9:00 AM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
>
> Good morning Erin, Alex, Malia and Heather,
> Thanks again for this terrific report! We are updating the paper now with new stats. In the meantime, we have had an opening for our state leadership calls for June 22 2-3pm eastern which we could use to highlight the findings of the Vital Signs report and lessons learned from our meeting and we have a couple of states available to give brief comments about their strategies. I am hoping that it is possible for you all to be available that day/time for the webinar with governors health policy advisors? It is usually very well attended and may help perpetuate the momentum around your report. Please let me know if it's possible and we can jump on a call and sort out details. Thanks!
> Sandra
>
> **From:** Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
> **Sent:** Thursday, June 7, 2018 1:34 PM
> **To:** Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
> **Cc:** Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
>
> I will be on leave July 16-20 and in an all-day meeting July 31.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 7, 2018 1:27 PM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Coleman, Akeiisa <AColeman@NGA.ORG>
> **Cc:** Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>

Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hello Erin and Team. Congratulations! We can't wait to review and will incorporate into the white paper and will share with our folks. The date for the webinar has not yet but set, but we are looking at July. Would it be possible for you to let us know of dates that do not work in July for at least one of your team to join and share the Vital Signs highlights? Thanks!

Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 9:56 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Sandra and Akeiisa,

As we mentioned, our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* will be released later today. The report includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions.

The CDC celebrates the National Governors Association's commitment to creating safe communities. We hope that this resource can provide state leaders with an increased understanding of the impact of suicide in their states, as well as potential solutions for prevention.

I would appreciate it if you could help disseminate the Vital Signs to your networks once the embargo lifts at 1:00 pm. Also, as discussed we will plan to highlight the Vital Signs on the planned Webinar with State health policy advisors (has a date been set yet?).

Erin

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state

public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

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CDC Vital Signs: Suicide rising across the U.S. More than a mental health concern



June 22, 2018

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 67 / No. 22
June 8, 2018

Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

Deborah M. Stone, ScD[1]; Thomas R. Simon PhD[1]; Katherine A. Fowler, PhD[1]; Scott R. Kegler, PhD[2]; Keming Yuan, MS[1]; Kristin M. Holland, PhD[1]; Asha Z. Ivey-Stephenson, PhD[1]; Alex E. Crosby, MD[1]

Deborah M. Stone, ScD, MSW, MPHBehavioral Scientist

Acknowledgements:

Co-AuthorsTom SimonKatherine FowlerScott KeglerKeming YuanKristin HollandAsha Ivey-StephensonAlex Crosby.

Communications/Policy TeamErin BlackMalia Richmond-CrumMarie BallmanMolly KurnitCrystal Bruce

Objectives



- Examine trends in state-level suicide rates Assess contributing factors to suicide Share prevention strategies based on the best available evidence

Vital Signs Methods Overview

National Vital Statistics System
Modeled average annual percentage change50 states, Washington, D.C.1999-2016 (3yr aggregates)RankingsCurrent state rankAbsolute rate change Percent change

National Violent Death Reporting System
2015, 27 StatesExamined DemographicDescriptive characteristics andContributing circumstances to suicideAmong people:with and without known mental health conditions



45K Nearly 45,000 lives lost to suicide in 2016.

↑ **30%** Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.

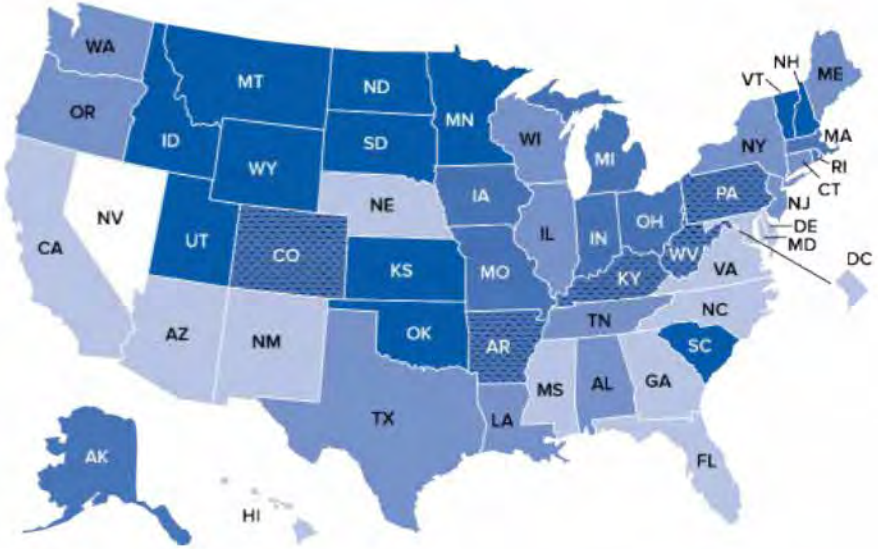
PROBLEM

SUICIDE RATES INCREASED INALMOS EVERY STATE.

Suicide rates rose across the USfrom 1999 to 2016.

- Increase 38 - 58%
- Increase 31 - 37%
- Increase 19 - 30%
- Increase 6 - 18%
- Decrease 1%

SOURCE: CDC's National Vital Statistics System; CDC Vital Signs, June 2018.



Many factors contribute to suicide among thosewith and without known mental health conditions.



Note: Persons who died by suicide may haveexperienced multiple factors. Data on mentalhealth conditions and contributing factors are fromcoroner/medical examiner and law enforcementreports. It is possible that mental health conditionsor other contributing factors could have beenpresent and not diagnosed, known, or reported.SOURCE: CDC's National Violent Death ReportingSystem, data from 27 states participating in 2015

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practiceshttps/::go.usa.gov/xQBGc

Provide financial support to individuals in need.



States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.



Healthcare systems can offer treatment options byphone or online where services are not widely available.

Create protective environments.



Employers can apply policies that create a healthyenvironment and reduce stigma about seeking help.

Connect people with their communities.



Communities can offer programs and events toincrease a sense of belonging among residents.

Teach coping and problem-solving skills.



Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.



Media can describe helping resources and avoid headlines or details that increase risk.

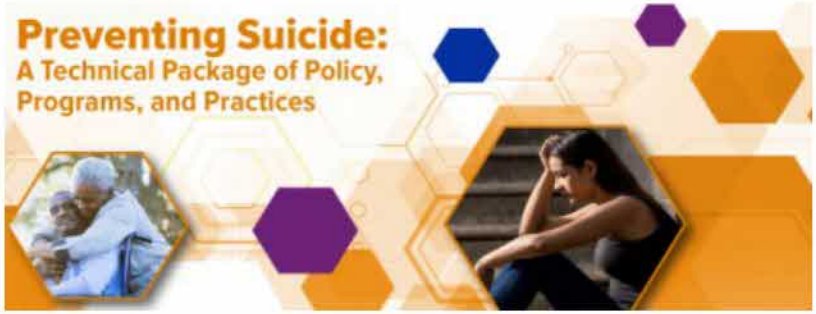
Identify and support people at risk.



Everyone can learn the warning signs for suicide, how to respond, and where to get help.

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT ISTracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).Developing, implementing, and evaluating suicide prevention strategies.Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).



STATES AND COMMUNITIES CANIdentify and support people at risk of suicide.Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.Offer activities that bring people together so they feel connected and not alone.Connect people at risk to effective and coordinated mental and physical healthcare.Expand options for temporary assistance for those struggling to make ends meet.Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

WHAT CAN BE DONE

HEALTH CARE SYSTEMS CANProvide high-quality, ongoing care focused on patient safety and suicide prevention.Make sure affordable and effective mental and physical healthcare is available where people live.Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CANPromote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.Encourage employees to seek help. Provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CANAsk someone you are worried about if they're thinking about suicide.Keep them safe. Reduce access to lethal means for those at risk.Be there with them. Listen to what they need.Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).Follow up to see how they're doing.Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk(e.g., by not using dramatic headlines orproviding explicit details) and encouragepeople to seek help.View recommendations available at:www.ReportingOnSuicide.org

Preventing suicide involves everyone in the community.





NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org



Thank You!

www.cdc.gov/vitalsigns.suicidewww.cdc.gov/mmwr

dstone3@cdc.gov

For more information, please contact1-800-CDC-INFO (232-4636)TTY: 1-888-232-6348 | www.cdc.govCenters for Disease Control and Prevention1600 Clifton Road NE, Atlanta GA 30333

The findings and conclusions in this presentation are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: 20 Jun 2018 16:39:11 -0400
To: Coleman, Akeiisa
Cc: Black, Erin (CDC/ONDIEH/NCIPC);Dennehy, Heather (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Wilkniss, Sandra
Subject: RE: June 22 webinar - CDC introduction slides
Attachments: NGA intro slides_20June18.pptx

Greetings:
I have attached the slides.
Alex C

From: Wilkniss, Sandra
Sent: Friday, June 15, 2018 11:25 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Black, Erin (CDC/ONDIEH/NCIPC) ; Coleman, Akeiisa ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Dennehy, Heather (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Re: June 22 webinar

Wonderful!

On Jun 15, 2018, at 9:27 AM, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov> wrote:

> Greetings:
> It looks like I am available on the 22nd for the webinar & on Weds, 20th for the pre-brief.
> Alex C
>
> ---
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Date:** June 15, 2018 at 6:45:31 AM EDT
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Coleman, Akeiisa <AColeman@NGA.ORG>, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>, Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>, Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
> **Subject:** Re: June 22 webinar
> Great. Will send and invitation for Wednesday at 3:30-4. I could talk later in the day on Monday if you want to do it sooner, but am stuck before noon. thanks!
> Sandra
>
> ---
>
> **From:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Sent:** Thursday, June 14, 2018 11:34:07 PM
> **To:** Wilkniss, Sandra
> **Cc:** Coleman, Akeiisa; Crosby, Alexander (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Dennehy, Heather (CDC/ONDIEH/NCIPC); Stone, Deborah

(CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar
Yes, it would be helpful if you could schedule a pre-brief next week. From a quick peek at calendars it looks like Alex, Deb and myself might be available Monday 10:30-11 or Wed 3:30-4.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 11:25 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Coleman, Akeiisa <AColeman@NGA.ORG>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar
Hello Erin and Dr Stone.
We can be flexible in the federal overview and take your lead on the data to highlight as well as any priority strategies, federal-state partnership aimed at preventing suicide you would like to share. May we schedule a call with the three of you for when Alex returns early next week to plan? Thank you!
Sandra

On Jun 14, 2018, at 11:19 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Ladies – what does the federal overview in the agenda below consist of? As mentioned I plan to be on the call, also the Vital Signs lead author, Deb Stone (copied), will be on the call to present on the Vital Signs. Alex is currently on leave but back next week to discuss his availability.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 14, 2018 1:25 PM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Coleman, Akeiisa <AColeman@NGA.ORG>
> **Subject:** June 22 webinar
> Hi again, Erin. We just discussed the layout for this webinar and wanted to bullet it out for you for discussion you are having at CDC:
> Call is June 22 from 2 – 3pm eastern with governors health policy adivisors (all states and territories invited)
> 5 minutes flex time for people to get on the call and announce themselves
> 10 min federal overview
> 2 min overview of what to expect – NGA
> 5-7 min CDC talking about recent data
> 5-7 min NGA to summarize meeting highlights
> 5-7 min state rep from CO to talk about their comprehensive approach
> 5-7 min ID/UT rep to talk about prevention or partnership (this is being nailed down in the next couple days)
> 15 min Q & A
> We will be able to show slides.
> I hope this helps!
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 14, 2018 10:50 AM

To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

HI Erin,

It is still being reviewed internally. So, we had hoped to do the webinar after the paper was done. However, the opportunity on the 22nd came up and we thought it more important to capitalize on the momentum of your recent report rather than wait for our paper to be final. We think it critical to get attention to the issue while its top of mind. Sound ok?

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 14, 2018 10:25 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Have you sent us a copy of the report yet from the convening that you will be discussing on the call? I will be on the call but also still confirming if others will attend. Alex is out until Monday.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 9:49 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: Re: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin -

We have all things ready to go for the webinar next Friday. Are you ok to cover the new data and/or can others join the call? We are super excited to highlight and get the info to all governors. Thanks!

On Jun 12, 2018, at 1:30 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Sandra – I am available that day/time – but let me check internally and see who would be best to present on the VS and get back to you.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Tuesday, June 12, 2018 9:00 AM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
>
> Good morning Erin, Alex, Malia and Heather,
>
> Thanks again for this terrific report! We are updating the paper now with new stats. In the meantime, we have had an opening for our state leadership calls for June 22 2-3pm eastern which we could use to highlight the findings of the Vital Signs report

and lessons learned from our meeting and we have a couple of states available to give brief comments about their strategies. I am hoping that it is possible for you all to be available that day/time for the webinar with governors health policy advisors? It is usually very well attended and may help perpetuate the momentum around your report. Please let me know if it's possible and we can jump on a call and sort out details. Thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 1:34 PM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

I will be on leave July 16-20 and in an all-day meeting July 31.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 7, 2018 1:27 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hello Erin and Team. Congratulations! We can't wait to review and will incorporate into the white paper and will share with our folks. The date for the webinar has not yet but set, but we are looking at July. Would it be possible for you to let us know of dates that do not work in July for at least one of your team to join and share the Vital Signs highlights? Thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 9:56 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Sandra and Akeiisa,
As we mentioned, our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* will be released later today. The report includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions.
The CDC celebrates the National Governors Association's commitment to creating safe communities. We hope that this resource can provide state leaders with an increased understanding of the impact of suicide in their states, as well as potential solutions for prevention.
I would appreciate it if you could help disseminate the Vital Signs to your networks once the embargo lifts at 1:00 pm. Also, as discussed we will plan to highlight the Vital Signs on the planned Webinar with State health policy advisors (has a date been set yet?).
Erin

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate

that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

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Support for states to prevent suicidal behavior

National Governors Association
Center for Best Practices Webinar
June 2018

Alex Crosby, MDDivision of Violence PreventionCenters for Disease Control and Prevention

"The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry."

Supporting State Health Departments



Examples of available resources

- **Surveillance datawww.cdc.gov/ncipc/wisqars/default.htmResearchhttps://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdfPrevention programshttps://www.cdc.gov/violenceprevention/pub/technical-packages.html#suicide**



Age-adjusted suicide rates among all persons by state -- United States, 2016 (U.S. avg 13.5)



Source: CDC vital statistics

Thank You Being a Suicide Prevention Champion!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 21 Jun 2018 14:58:09 +0000
To: Crosby, Alexander (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC)
Cc: Dennehy, Heather (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar

Looks good to me too!
Thanks,
Deb

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 21, 2018 10:52 AM
To: Black, Erin (CDC/ONDIEH/NCIPC)
Cc: Dennehy, Heather (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar

Greetings:
Looks good. Just a couple of suggestions. Please see below.
Alex C

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 21, 2018 10:47 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: June 22 webinar

Here are the TPs Heather and I were thinking for my portion, let me know what you think before I send to NGA.

- In March, in Denver, Colorado, DVP collaborated with the National Governor's Association and SAMHSA to convene state leaders from 13 states with a high burden of suicide to hear suicide prevention best practices from the ~~Bureau of Indian Affairs~~, Indian Health Service, the VA, SAMHSA, and CO state who is implementing a comprehensive suicide prevention pilot.
- CDC specifically sought out this partnership with NGA as a way to leverage their relationship with you, the state health policy advisors and the importance of your role in informing state policy. We want to be a resource for you as you work to reduce the rising suicide rates across the nation. These rising rates are outlined in our recent CDC Vital Signs on state suicide trends.
- We want you to know that comprehensive suicide prevention includes policy options, such as unemployment benefits, neighborhood stabilization, mental health parity, alcohol outlet density, and greening polices that can help prevent suicide. These and other best available evidence are outlined in our CDC Suicide Prevention Technical Package for Preventing suicide.
- We want to be a resource for you in gathering the suicide prevention data necessary to inform policy decisions.
- Sandra Wilkniss will be sharing a little bit more about the convening we had in March, and my colleagues from CDC, Deb Stone and Alex Crosby will be talking more about CDC's

work in suicide prevention, the latest data from our CDC's Vital Signs on suicide prevention, and the strategies and approaches from our suicide prevention technical package that we know work to prevent suicide.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 4:52 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: June 22 webinar

No, nothing changed. I just streamlined the talking points a bit.
Deb

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 4:42 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: June 22 webinar

Hi Deb- Did anything change from the VS Town Hall?

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 4:40 PM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: June 22 webinar

Thanks, Alex. I'm going to go ahead and send them in a few mins.
Deb

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 4:39 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: June 22 webinar

Greetings:
I think those look good.
Alex C

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 3:58 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Subject: RE: June 22 webinar

Hi Guys,
These are the slides and talking points I had. Do you think these are ok?
Deb

From: Coleman, Akeiisa <AColeman@NGA.ORG>
Sent: Monday, June 18, 2018 11:07 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Wilkniss, Sandra <SWilkniss@NGA.ORG>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Picher, Caroline <CPicher@NGA.ORG>
Subject: RE: June 22 webinar

Attached is a calendar invite that was shared with governors' staff and health secretaries. Also, here is the link to register for the webinar:
https://attendee.gotowebinar.com/register/2910584691522729474

Akeiisa Coleman, MSW
Senior Policy Analyst, Health Division
National Governors Association
202.624.5344 | acoleman@nga.org

From: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Sent: Monday, June 18, 2018 10:42 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Subject: RE: June 22 webinar

Can you please forward the invitation for the webinar on Friday so that we have it on our calendars and have the call-in information. Thank you.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Friday, June 15, 2018 11:25 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Coleman, Akeiisa <AColeman@NGA.ORG>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar

Wonderful!

On Jun 15, 2018, at 9:27 AM, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov> wrote:

> Greetings:
> It looks like I am available on the 22nd for the webinar & on Weds, 20th for the pre-brief.
> Alex C

> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Date:** June 15, 2018 at 6:45:31 AM EDT
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Coleman, Akeiisa <AColeman@NGA.ORG>, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>, Richmond-Crum, Malia

(CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>, Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar
Great. Will send and invitation for Wednesday at 3:30-4. I could talk later in the day on Monday if you want to do it sooner, but am stuck before noon. thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Sent: Thursday, June 14, 2018 11:34:07 PM
To: Wilkniss, Sandra
Cc: Coleman, Akeiisa; Crosby, Alexander (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Dennehy, Heather (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar
Yes, it would be helpful if you could schedule a pre-brief next week. From a quick peek at calendars it looks like Alex, Deb and myself might be available Monday 10:30-11 or Wed 3:30-4.

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Cc: Coleman, Akeiisa <AColeman@NGA.ORG>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
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> Call is June 22 from 2 – 3pm eastern with governors health policy adivisors (all states and territories invited)

5 minutes flex time for people to get on the call and announce themselves
10 min federal overview
2 min overview of what to expect – NGA
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5-7 min NGA to summarize meeting highlights
5-7 min state rep from CO to talk about their comprehensive approach
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I hope this helps!

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To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

HI Erin,
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Good morning Erin, Alex, Malia and Heather,
Thanks again for this terrific report! We are updating the paper now with new stats. In the meantime, we have had an opening for our state leadership calls for June 22 2-3pm eastern which we could use to highlight the findings of the Vital Signs report and lessons learned from our meeting and we have a couple of states available to give brief comments about their strategies. I am hoping that it is possible for you all to be available that day/time for the webinar with governors health policy advisors? It is usually very well attended and may help perpetuate the momentum around your report. Please let me know if it's possible and we can jump on a call and sort out details. Thanks!
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Hello Erin and Team. Congratulations! We can't wait to review and will incorporate into the white paper and will share with our folks. The date for the webinar has not yet but set, but we are looking at July. Would it be possible for you to let us know

of dates that do not work in July for at least one of your team to join and share the Vital Signs highlights? Thanks!
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Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Sandra and Akeiisa,

As we mentioned, our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* will be released later today. The report includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions.

The CDC celebrates the National Governors Association's commitment to creating safe communities. We hope that this resource can provide state leaders with an increased understanding of the impact of suicide in their states, as well as potential solutions for prevention.

I would appreciate it if you could help disseminate the Vital Signs to your networks once the embargo lifts at 1:00 pm. Also, as discussed we will plan to highlight the Vital Signs on the planned Webinar with State health policy advisors (has a date been set yet?).

Erin

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today,**

Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

The information contained in this electronic transmission, including any attachments, is for the exclusive use of the intended recipient(s) and may contain information that is privileged, proprietary, and/or confidential. If the reader of this transmission is not an intended recipient, or a person responsible for delivering it to the intended recipient, you are hereby notified that any review, dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify the sender and delete this message.

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From: Coleman, Akeiisa
Sent: 18 Jun 2018 21:09:55 +0000
To: Black, Erin (CDC/ONDIEH/NCIPC);Wilkniss, Sandra
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Dennehy, Heather (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Picher, Caroline
Subject: RE: June 22 webinar

Afternoon all!
I know we're talking on Wednesday to prep for Friday's webinar. If anyone plans to use a couple slides for their piece, we'd appreciate it if you could send these by the end of the day Wednesday.
Additionally, Caroline, who is handling the webinar logistics, would like to do a quick check to make sure everyone's comfortable using Go To Meeting.
Thanks,
Akeiisa
Akeiisa Coleman, MSW
Senior Policy Analyst, Health Division
National Governors Association
202.624.5344 | acoleman@nga.org

From: Coleman, Akeiisa
Sent: Monday, June 18, 2018 11:07 AM
To: 'Black, Erin (CDC/ONDIEH/NCIPC)' ; Wilkniss, Sandra
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Attached is a calendar invite that was shared with governors' staff and health secretaries. Also, here is the link to register for the webinar:
https://attendee.gotowebinar.com/register/2910584691522729474
Akeiisa Coleman, MSW
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National Governors Association
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Can you please forward the invitation for the webinar on Friday so that we have it on our calendars and have the call-in information. Thank you.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Friday, June 15, 2018 11:25 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Coleman, Akeiisa <AColeman@NGA.ORG>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
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Wonderful!

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> Greetings:
> It looks like I am available on the 22nd for the webinar & on Weds, 20th for the pre-brief.
> Alex C

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Date: June 15, 2018 at 6:45:31 AM EDT
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Great. Will send and invitation for Wednesday at 3:30-4. I could talk later in the day on Monday if you want to do it sooner, but am stuck before noon. thanks!
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I would appreciate it if you could help disseminate the Vital Signs to your networks once the embargo lifts at 1:00 pm. Also, as discussed we will plan to highlight the Vital Signs on the

planned Webinar with State health policy advisors (has a date been set yet?).
Erin

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join

us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

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From: Coleman, Akeiisa
Sent: 18 Jun 2018 15:07:01 +0000
To: Black, Erin (CDC/ONDIEH/NCIPC);Wilkniss, Sandra
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Dennehy, Heather (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Picher, Caroline
Subject: RE: June 22 webinar
Attachments: Governors' Health Care Leadership Webinar on State Strategies for Suicide Prevention.msg

Attached is a calendar invite that was shared with governors' staff and health secretaries. Also, here is the link to register for the webinar:
https://attendee.gotowebinar.com/register/2910584691522729474
Akeiisa Coleman, MSW
Senior Policy Analyst, Health Division
National Governors Association
202.624.5344 | acoleman@nga.org

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Monday, June 18, 2018 10:42 AM
To: Wilkniss, Sandra ; Coleman, Akeiisa
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Dennehy, Heather (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar

Can you please forward the invitation for the webinar on Friday so that we have it on our calendars and have the call-in information. Thank you.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Friday, June 15, 2018 11:25 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Coleman, Akeiisa <AColeman@NGA.ORG>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar

Wonderful!

On Jun 15, 2018, at 9:27 AM, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov> wrote:

> Greetings:
> It looks like I am available on the 22nd for the webinar & on Weds, 20th for the pre-brief.
> Alex C

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Date: June 15, 2018 at 6:45:31 AM EDT
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Coleman, Akeiisa <AColeman@NGA.ORG>, Crosby, Alexander

(CDC/ONDIEH/NCIPC) <aec1@cdc.gov>, Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>, Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar
Great. Will send and invitation for Wednesday at 3:30-4. I could talk later in the day on Monday if you want to do it sooner, but am stuck before noon. thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Sent: Thursday, June 14, 2018 11:34:07 PM
To: Wilkniss, Sandra
Cc: Coleman, Akeiisa; Crosby, Alexander (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Dennehy, Heather (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar
Yes, it would be helpful if you could schedule a pre-brief next week. From a quick peek at calendars it looks like Alex, Deb and myself might be available Monday 10:30-11 or Wed 3:30-4.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 11:25 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Coleman, Akeiisa <AColeman@NGA.ORG>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar
Hello Erin and Dr Stone.
We can be flexible in the federal overview and take your lead on the data to highlight as well as any priority strategies, federal-state partnership aimed at preventing suicide you would like to share. May we schedule a call with the three of you for when Alex returns early next week to plan? Thank you!
Sandra

On Jun 14, 2018, at 11:19 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Ladies – what does the federal overview in the agenda below consist of? As mentioned I plan to be on the call, also the Vital Signs lead author, Deb Stone (copied), will be on the call to present on the Vital Signs. Alex is currently on leave but back next week to discuss his availability.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Thursday, June 14, 2018 1:25 PM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
> **Cc:** Coleman, Akeiisa <AColeman@NGA.ORG>
> **Subject:** June 22 webinar
> Hi again, Erin. We just discussed the layout for this webinar and wanted to bullet it out for you for discussion you are having at CDC:

Call is June 22 from 2 – 3pm eastern with governors health policy adivisors (all states and territories invited)
5 minutes flex time for people to get on the call and announce themselves
10 min federal overview
2 min overview of what to expect – NGA
5-7 min CDC talking about recent data
5-7 min NGA to summarize meeting highlights
5-7 min state rep from CO to talk about their comprehensive approach
5-7 min ID/UT rep to talk about prevention or partnership (this is being nailed down in the next couple days)
15 min Q & A
We will be able to show slides.
I hope this helps!

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 10:50 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

HI Erin,
It is still being reviewed internally. So, we had hoped to do the webinar after the paper was done. However, the opportunity on the 22nd came up and we thought it more important to capitalize on the momentum of your recent report rather than wait for our paper to be final. We think it critical to get attention to the issue while its top of mind. Sound ok?

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 14, 2018 10:25 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Have you sent us a copy of the report yet from the convening that you will be discussing on the call? I will be on the call but also still confirming if others will attend. Alex is out until Monday.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 9:49 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: Re: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin -
We have all things ready to go for the webinar next Friday. Are you ok to cover the new data and/or can others join the call? We are super excited to highlight and get the info to all governors. Thanks!

On Jun 12, 2018, at 1:30 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

Sandra – I am available that day/time – but let me check internally and see who would be best to present on the VS and get back to you.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Tuesday, June 12, 2018 9:00 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Good morning Erin, Alex, Malia and Heather,
Thanks again for this terrific report! We are updating the paper now with new stats. In the meantime, we have had an opening for our state leadership calls for June 22 2-3pm eastern which we could use to highlight the findings of the Vital Signs report and lessons learned from our meeting and we have a couple of states available to give brief comments about their strategies. I am hoping that it is possible for you all to be available that day/time for the webinar with governors health policy advisors? It is usually very well attended and may help perpetuate the momentum around your report. Please let me know if it's possible and we can jump on a call and sort out details. Thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 1:34 PM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

I will be on leave July 16-20 and in an all-day meeting July 31.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 7, 2018 1:27 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hello Erin and Team. Congratulations! We can't wait to review and will incorporate into the white paper and will share with our folks. The date for the webinar has not yet but set, but we are looking at July. Would it be possible for you to let us know of dates that do not work in July for at least one of your team to join and share the Vital Signs highlights? Thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 7, 2018 9:56 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Sandra and Akeiisa,
As we mentioned, our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* will be released later today. The report includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions.
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I would appreciate it if you could help disseminate the Vital Signs to your networks once the embargo lifts at 1:00 pm. Also, as discussed we will plan to highlight the Vital Signs on the planned Webinar with State health policy advisors (has a date been set yet?).
Erin

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Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

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From: Picher, Caroline
Sent: 14 Jun 2018 22:32:29 +0000
To: Picher, Caroline
Subject: Governors' Health Care Leadership Webinar on State Strategies for Suicide Prevention

Please register for Governors' Health Care Leadership Call on State Strategies for Suicide Prevention on Jun 22, 2018 2:00 PM EDT at:

https://attendee.gotowebinar.com/register/2910584691522729474

After registering, you will receive a confirmation email containing information about joining the webinar.
Agenda TBD

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 21 Jun 2018 07:43:35 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Dennehy, Heather (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar

Got it. Thanks.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 4:52 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Dennehy, Heather (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar

No, nothing changed. I just streamlined the talking points a bit.
Deb

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 4:42 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: June 22 webinar

Hi Deb- Did anything change from the VS Town Hall?

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 4:40 PM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: June 22 webinar

Thanks, Alex. I'm going to go ahead and send them in a few mins.
Deb

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 4:39 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: June 22 webinar

Greetings:
I think those look good.
Alex C

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 3:58 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Subject: RE: June 22 webinar

Hi Guys,
These are the slides and talking points I had. Do you think these are ok?

Deb

From: Coleman, Akeiisa <AColeman@NGA.ORG>
Sent: Monday, June 18, 2018 11:07 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Wilkniss, Sandra <SWilkniss@NGA.ORG>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Picher, Caroline <CPicher@NGA.ORG>
Subject: RE: June 22 webinar

Attached is a calendar invite that was shared with governors' staff and health secretaries. Also, here is the link to register for the webinar:
https://attendee.gotowebinar.com/register/2910584691522729474

Akeiisa Coleman, MSW
Senior Policy Analyst, Health Division
National Governors Association
202.624.5344 | acoleman@nga.org

From: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Sent: Monday, June 18, 2018 10:42 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Subject: RE: June 22 webinar

Can you please forward the invitation for the webinar on Friday so that we have it on our calendars and have the call-in information. Thank you.

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Good morning Erin, Alex, Malia and Heather,
Thanks again for this terrific report! We are updating the paper now with new stats. In the meantime, we have had an opening for our state leadership calls for June 22 2-3pm eastern which we could use to highlight the findings of the Vital Signs report and lessons learned from our meeting and we have a couple of states available to give brief comments about their strategies. I am hoping that it is possible for you all to be available that day/time for the webinar with governors health policy advisors? It is usually very well attended and may help perpetuate the momentum around your report. Please let me know if it's possible and we can jump on a call and sort out details. Thanks!
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I will be on leave July 16-20 and in an all-day meeting July 31.

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Hello Erin and Team. Congratulations! We can't wait to review and will incorporate into the white paper and will share with our folks. The date for the webinar has not yet but set, but we are looking at July. Would it be possible for you to let us know of dates that do not work in July for at least one of your team to join and share the Vital Signs highlights? Thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
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Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Sandra and Akeiisa,

As we mentioned, our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* will be released later today. The report includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions.

The CDC celebrates the National Governors Association's commitment to creating safe communities. We hope that this resource can provide state leaders with an increased understanding of the impact of suicide in their states, as well as potential solutions for prevention.

I would appreciate it if you could help disseminate the Vital Signs to your networks once the embargo lifts at 1:00 pm. Also, as discussed we will plan to highlight the Vital Signs on the planned Webinar with State health policy advisors (has a date been set yet?).

Erin

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly*

Report (MMWR) article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

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From: Dennehy, Heather (CDC/ONDIEH/NCIPC)
Sent: 20 Jun 2018 16:39:56 -0400
To: Crosby, Alexander (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar

Agreed! They look great to me!

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 20, 2018 4:39 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
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Hi Guys,
These are the slides and talking points I had. Do you think these are ok?
Deb

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Attached is a calendar invite that was shared with governors' staff and health secretaries. Also, here is the link to register for the webinar:
https://attendee.gotowebinar.com/register/2910584691522729474
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> **Cc:** Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
>
> Good morning Erin, Alex, Malia and Heather,
> Thanks again for this terrific report! We are updating the paper now with new stats. In the meantime, we have had an opening for our state leadership calls for June 22 2-3pm eastern which we could use to highlight the findings of the Vital Signs report and lessons learned from our meeting and we have a couple of states available to give brief comments about their strategies. I am hoping that it is possible for you all to be available that day/time for the webinar with governors health policy advisors? It is usually very well attended and may help perpetuate the momentum around your report. Please let me know if it's possible and we can jump on a call and sort out details. Thanks!
> Sandra
>
> **From:** Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]

Sent: Thursday, June 7, 2018 1:34 PM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

I will be on leave July 16-20 and in an all-day meeting July 31.

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Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hello Erin and Team. Congratulations! We can't wait to review and will incorporate into the white paper and will share with our folks. The date for the webinar has not yet but set, but we are looking at July. Would it be possible for you to let us know of dates that do not work in July for at least one of your team to join and share the Vital Signs highlights? Thanks!
Sandra

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Sent: Thursday, June 7, 2018 9:56 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
Subject: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Sandra and Akeiisa,
As we mentioned, our new Vital Signs, *Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates,* will be released later today. The report includes state-level trends in suicide rates from 1999-2016, and, with data from CDC's National Violent Death Reporting System, looks at the circumstances of suicide among people with and without known mental health conditions.
The CDC celebrates the National Governors Association's commitment to creating safe communities. We hope that this

resource can provide state leaders with an increased understanding of the impact of suicide in their states, as well as potential solutions for prevention.
I would appreciate it if you could help disseminate the Vital Signs to your networks once the embargo lifts at 1:00 pm. Also, as discussed we will plan to highlight the Vital Signs on the planned Webinar with State health policy advisors (has a date been set yet?).
Erin

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Webpage to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the

Vital Signs buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

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From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 20 Jun 2018 19:58:10 +0000
To: Black, Erin (CDC/ONDIEH/NCIPC)
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Dennehy, Heather (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar
Attachments: Vital Signs NGA Meeting 6.22.18.pptx

Hi Guys,
These are the slides and talking points I had. Do you think these are ok?
Deb

From: Coleman, Akeiisa
Sent: Monday, June 18, 2018 11:07 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) ; Wilkniss, Sandra
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Dennehy, Heather (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Picher, Caroline
Subject: RE: June 22 webinar

Attached is a calendar invite that was shared with governors' staff and health secretaries. Also, here is the link to register for the webinar:
https://attendee.gotowebinar.com/register/2910584691522729474
Akeiisa Coleman, MSW
Senior Policy Analyst, Health Division
National Governors Association
202.624.5344 | acoleman@nga.org

From: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Sent: Monday, June 18, 2018 10:42 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>; Coleman, Akeiisa <AColeman@NGA.ORG>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Subject: RE: June 22 webinar

Can you please forward the invitation for the webinar on Friday so that we have it on our calendars and have the call-in information. Thank you.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Friday, June 15, 2018 11:25 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Coleman, Akeiisa <AColeman@NGA.ORG>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar

Wonderful!

On Jun 15, 2018, at 9:27 AM, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov> wrote:

Greetings:

It looks like I am available on the 22nd for the webinar & on Weds, 20th for the pre-brief.
Alex C

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Date: June 15, 2018 at 6:45:31 AM EDT
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Coleman, Akeiisa <AColeman@NGA.ORG>, Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>, Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>, Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>, Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar
Great. Will send and invitation for Wednesday at 3:30-4. I could talk later in the day on Monday if you want to do it sooner, but am stuck before noon. thanks!
Sandra

From: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Sent: Thursday, June 14, 2018 11:34:07 PM
To: Wilkniss, Sandra
Cc: Coleman, Akeiisa; Crosby, Alexander (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Dennehy, Heather (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: June 22 webinar
Yes, it would be helpful if you could schedule a pre-brief next week. From a quick peek at calendars it looks like Alex, Deb and myself might be available Monday 10:30-11 or Wed 3:30-4.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 11:25 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Coleman, Akeiisa <AColeman@NGA.ORG>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Re: June 22 webinar
Hello Erin and Dr Stone.
We can be flexible in the federal overview and take your lead on the data to highlight as well as any priority strategies, federal-state partnership aimed at preventing suicide you would like to share. May we schedule a call with the three of you for when Alex returns early next week to plan? Thank you!
Sandra

On Jun 14, 2018, at 11:19 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Ladies – what does the federal overview in the agenda below consist of? As mentioned I plan to be on the call, also the Vital Signs lead author, Deb Stone

(copied), will be on the call to present on the Vital Signs. Alex is currently on leave but back next week to discuss his availability.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 1:25 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Coleman, Akeiisa <AColeman@NGA.ORG>
Subject: June 22 webinar

Hi again, Erin. We just discussed the layout for this webinar and wanted to bullet it out for you for discussion you are having at CDC:
Call is June 22 from 2 – 3pm eastern with governors health policy adivisors (all states and territories invited)
5 minutes flex time for people to get on the call and announce themselves
10 min federal overview
2 min overview of what to expect – NGA
5-7 min CDC talking about recent data
5-7 min NGA to summarize meeting highlights
5-7 min state rep from CO to talk about their comprehensive approach
5-7 min ID/UT rep to talk about prevention or partnership (this is being nailed down in the next couple days)
15 min Q & A
We will be able to show slides.
I hope this helps!

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 10:50 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

HI Erin,
It is still being reviewed internally. So, we had hoped to do the webinar after the paper was done. However, the opportunity on the 22nd came up and we thought it more important to capitalize on the momentum of your recent report rather than wait for our paper to be final. We think it critical to get attention to the issue while its top of mind. Sound ok?

From: Black, Erin (CDC/ONDIEH/NCIPC) [mailto:epm7@cdc.gov]
Sent: Thursday, June 14, 2018 10:25 AM
To: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Subject: RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Have you sent us a copy of the report yet from the convening that you will be discussing on the call? I will be on the call but also still confirming if others will attend. Alex is out until Monday.

From: Wilkniss, Sandra <SWilkniss@NGA.ORG>
Sent: Thursday, June 14, 2018 9:49 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: Re: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Hi Erin -

We have all things ready to go for the webinar next Friday. Are you ok to cover the new data and/or can others join the call? We are super excited to highlight and get the info to all governors. Thanks!

On Jun 12, 2018, at 1:30 PM, Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov> wrote:

> Sandra – I am available that day/time – but let me check internally and see who would be best to present on the VS and get back to you.
>
> **From:** Wilkniss, Sandra <SWilkniss@NGA.ORG>
> **Sent:** Tuesday, June 12, 2018 9:00 AM
> **To:** Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
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> **Cc:** Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Dennehy, Heather (CDC/ONDIEH/NCIPC) <kvz6@cdc.gov>
> **Subject:** RE: EMBARGOED Until 1pm June 7: Vital Signs, Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
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CDC Vital Signs: Suicide rising across the U.S. More than a mental health concern



June 22, 2018

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 67 / No. 22
June 8, 2018

Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

Deborah M. Stone, ScD[1]; Thomas R. Simon PhD[1]; Katherine A. Fowler, PhD[1]; Scott R. Kegler, PhD[2]; Keming Yuan, MS[1]; Kristin M. Holland, PhD[1]; Asha Z. Ivey-Stephenson, PhD[1]; Alex E. Crosby, MD[1]

Deborah M. Stone, ScD, MSW, MPHBehavioral Scientist

Acknowledgements:

Co-AuthorsTom SimonKatherine FowlerScott KeglerKeming YuanKristin HollandAsha Ivey-StephensonAlex Crosby.

Communications/Policy TeamErin BlackMalia Richmond-CrumMarie BallmanMolly KurnitCrystal Bruce

Objectives



- Examine trends in state-level suicide rates Assess contributing factors to suicide Share prevention strategies based on the best available evidence

Vital SignsMethods Overview

National Vital Statistics System
Modeled average annual percentage change50 states, Washington, D.C.1999-2016 (3yr aggregates)RankingsCurrent state rankAbsolute rate change Percent change

National Violent Death Reporting System
2015, 27 StatesExamined DemographicDescriptive characteristics andContributing circumstances to suicideAmong people:with and without known mental health conditions



45K Nearly 45,000 lives lost to suicide in 2016.

↑ **30%** Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.

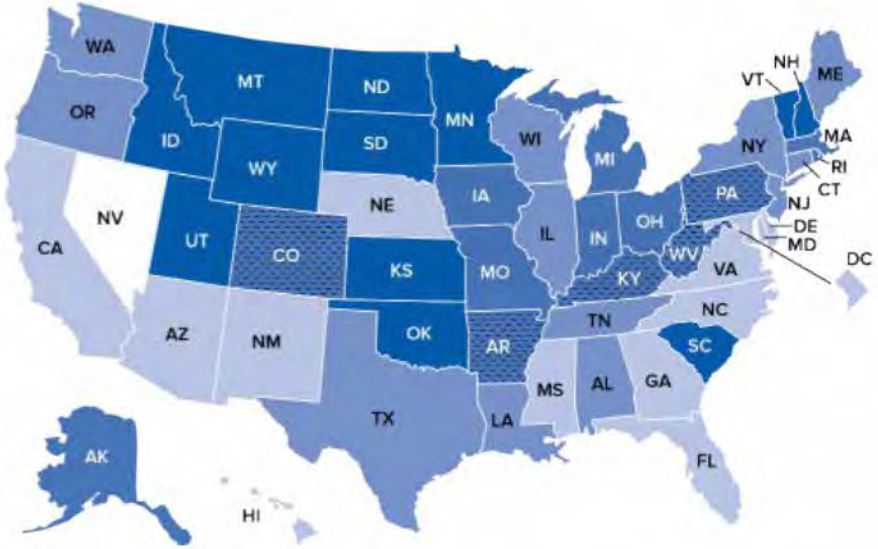
PROBLEM

SUICIDE RATES INCREASED INALMOS EVERY STATE.

Suicide rates rose across the USfrom 1999 to 2016.

- Increase 38 - 58%
- Increase 31 - 37%
- Increase 19 - 30%
- Increase 6 - 18%
- Decrease 1%

SOURCE: CDC's National Vital Statistics System; CDC Vital Signs, June 2018.



Many factors contribute to suicide among thosewith and without known mental health conditions.



Note: Persons who died by suicide may haveexperienced multiple factors. Data on mentalhealth conditions and contributing factors are fromcoroner/medical examiner and law enforcementreports. It is possible that mental health conditionsor other contributing factors could have beenpresent and not diagnosed, known, or reported.SOURCE: CDC's National Violent Death ReportingSystem, data from 27 states participating in 2015

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practiceshttps/::go.usa.gov/xQBGc

Provide financial support to individuals in need.



States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.



Healthcare systems can offer treatment options byphone or online where services are not widely available.

Create protective environments.



Employers can apply policies that create a healthyenvironment and reduce stigma about seeking help.

Connect people with their communities.



Communities can offer programs and events toincrease a sense of belonging among residents.

Teach coping and problem-solving skills.



Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.



Media can describe helping resources and avoid headlines or details that increase risk.

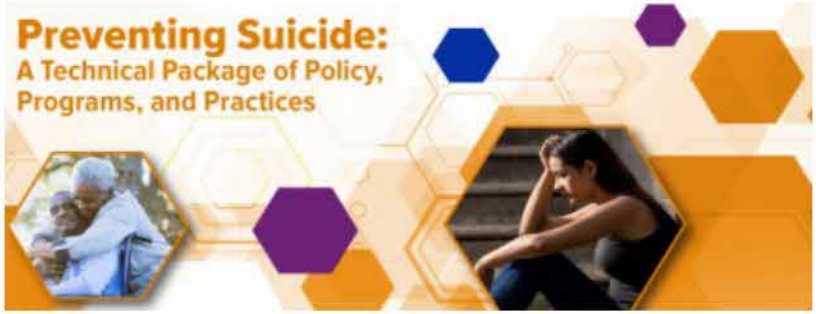
Identify and support people at risk.



Everyone can learn the warning signs for suicide, how to respond, and where to get help.

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT ISTracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).Developing, implementing, and evaluating suicide prevention strategies.Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).



STATES AND COMMUNITIES CANIdentify and support people at risk of suicide.Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.Offer activities that bring people together so they feel connected and not alone.Connect people at risk to effective and coordinated mental and physical healthcare.Expand options for temporary assistance for those struggling to make ends meet.Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

WHAT CAN BE DONE

HEALTH CARE SYSTEMS CANProvide high-quality, ongoing care focused on patient safety and suicide prevention.Make sure affordable and effective mental and physical healthcare is available where people live.Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CANPromote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.Encourage employees to seek help. Provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CANAsk someone you are worried about if they're thinking about suicide.Keep them safe. Reduce access to lethal means for those at risk.Be there with them. Listen to what they need.Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).Follow up to see how they're doing.Find out why this can save a life by visiting: www.BeThe1To.com.

The media can avoid increasing suicide risk(e.g., by not using dramatic headlines orproviding explicit details) and encouragepeople to seek help.View recommendations available at:www.ReportingOnSuicide.org

Preventing suicide involves everyone in the community.





NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org



Thank You!

www.cdc.gov/vitalsigns.suicidewww.cdc.gov/mmwr

dstone3@cdc.gov

For more information, please contact1-800-CDC-INFO (232-4636)TTY: 1-888-232-6348 | www.cdc.govCenters for Disease Control and Prevention1600 Clifton Road NE, Atlanta GA 30333

The findings and conclusions in this presentation are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 22 Apr 2018 23:51:20 +0000
To: Sokler, Lynn (CDC/OD/OADC);Peaker, Brandy (CDC/OPHSS/CSELS/DPHID);Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID);Omisore, Shannon L. (CDC/OD/OADC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: June Vital Signs - Suicide Prevention - MMWR early draft

Thank you Lynn and Brandy for the information and guidance. I will go ahead and prepare the Scholar One submission but will not submit until the 25th in case the guidance changes for some reason.
Sincerely,
Deb

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, April 20, 2018 4:24 PM
To: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) ; Omisore, Shannon L. (CDC/OD/OADC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Sokler, Lynn (CDC/OD/OADC)
Subject: RE: June Vital Signs - Suicide Prevention - MMWR early draft

I believe that Katherine Lyon-Daniel will be sending to him to look over because he wanted to see it for him to do telebrief. Don't know about whether he will make any comments or when exactly he will look over it just for his own information. As Brandy says, no expecting him to have comments at this point, but you never know. We'll keep doing what we are doing within our process.
Lynn.

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: Friday, April 20, 2018 4:13 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: RE: June Vital Signs - Suicide Prevention - MMWR early draft

Just to clarify – Dr. Redfield did not review your MMWR when it was sent for review with the FS because he had just started as Director. As Dr. Redfield learns more about the agency, we'll get more guidance from OD on how he wants to engage with Vital Signs. Since he has requested a copy of your MMWR, if he has comments at this point, we will not expect you to incorporate them by the time the MMWR is due to ScholarOne on 4/25. We will work with the MMWR editors to let them know that his comments were just received and that you all will incorporate his requested changes in the first round of edits with the MMWR editors.
Thanks, Brandy

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: Friday, April 20, 2018 3:59 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
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Hi Deb – CDC/OD had the opportunity to review your MMWR when they reviewed the FS. They will review it again after it is submitted to ScholarOne. You may get more comments from them at that

point. No need to worry. They have already seen it once when reviewing the FS, they will see again during MMWR production, and then before the prebrief. They may not have many comments because it is written so well.
Brandy

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, April 20, 2018 3:36 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
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Subject: RE: June Vital Signs - Suicide Prevention - MMWR early draft

Hi Deb,
Didn't want you fretting over the weekend. Rich is out today and Rich and/or Brandy will get back to you – probably on Monday.
Thanks and have a good weekend.
Lynn

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, April 20, 2018 3:08 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: June Vital Signs - Suicide Prevention - MMWR early draft

Hello VS team. I'm concerned that I haven't gotten any comments back on our MMWR yet and revisions are due back on the 25th.
Do you have any information about this you can provide?
Thank you,
Deb

From: Sokler, Lynn (CDC/OD/OADC)
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To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
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Hi Folks,
Just wanted you to know that Dr. Redfield asked for a copy of the MMWR now so that he can determine whether he or Anne Schuchat will do the Telebriefing.
Either one is probably a good thing!
Will keep you posted.
Lynn

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, April 20, 2018 2:21 PM
To: Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>

Subject: June Vital Signs - Suicide Prevention - MMWR early draft
This is an early draft of the MMWR.

Currently, the pre-brief with Anne is set up for May 8.
To accommodate her travel schedule we set up the media telebrief and launch of the Vital Signs for Thursday, June 7. Invites have been issued.
If Dr. Redfield is able to and wants to do this one, is it possible to change to our normal Tuesday, June 5 schedule? FYI and isn't any deciding factor at all, but I am on leave and on a plane on June 7, but I am here on June 5.
Please let us know,
Thanks, Lynn

From: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Sent: 20 Apr 2018 16:18:24 -0400
To: Sokler, Lynn (CDC/OD/OADC);Stone, Deborah (CDC/ONDIEH/NCIPC);Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID);Omisore, Shannon L. (CDC/OD/OADC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: June Vital Signs - Suicide Prevention - MMWR early draft

Meant to add - Dr. Schuchat did review the MMWR when reviewing the FS and she did not have any comments. We don't expect any more comments from her until after the MMWR is submitted to ScholarOne.

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Please let us know,
Thanks, Lynn

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 09:09:09 -0400
To: Crosby, Alexander (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD);Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Media Messaging Work Group Call
Attachments: FINAL MATERIALS FOR DISTRIBUTION_ June 7 - Vital Signs Suicide Prevention.msg

Looks like you guys are all on the invite for the call with the Action Alliance Messaging Work Group today. Per Lynn Sokler's email attached we can distribute VS materials to key partners and constituents as of 9am today. Are you all ok with sharing an embargoed copy of the Fact Sheet with those on the invite in advance of the call this afternoon with the stipulation that it is embargoed until 1pm and cannot be shared or forwarded? On the call I will plan to briefly highlight the fact sheet and Molly will discuss our messaging plans.

-----Original Appointment-----
From: Torguson, Kimberly
Sent: Monday, May 14, 2018 6:59 PM
To: Torguson, Kimberly; Belyeu, Avery; jbenson@reingold.com; Black, Erin (CDC/ONDIEH/NCIPC); Bray, Miranda (SAMHSA/OC); Sam.Brinton@thetrevorproject.org; Bruce, Crystal (CDC/OPHPR/OD); Carr, Colleen; SCoggin@afsp.org; ccreighton@suicidology.org; Crosby, Alexander (CDC/ONDIEH/NCIPC); Curtin, Sally C. (CDC/OPHSS/NCHS); Daniel, Valerie M. (CDC/ONDIEH/NCIPC); Ashby.Dodge@thetrevorproject.org; mgdyak@eiconline.org; JohnD@mhaofnyc.org; fgonzalez@mhaofnyc.org; Gass, Jesse; Hausman, Bridgette; Hedegaard, Holly (CDC/OPHSS/NCHS); Holland, Kristin (CDC/ONDIEH/NCIPC); ajkulp@suicidology.org; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC); wendy.e.lakso.civ@mail.mil; plauricella@reingold.com; sheri.lunn@thetrevorproject.org; cmaxwell@suicidology.org; McElroy, James (NIH/NIMH) [E]; McShane, Kristen (SAMHSA/OC); steve.mendelsohn@thetrevorproject.org; eneely@reingold.com; AOBrien@afsp.org; O'Keefe, Lindsey (NIH/NIMH) [E]; Amit.Paley@thetrevorproject.org; jpearson@nih.gov; Pearson, Jane L (NIH/NIMH) [E]; Reed, Jerry; dreidenberg@save.org; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); mrosen@mhaofnyc.org; michaelle.scanlon@nih.gov; Sobottka, Linda; Stone, Deborah (CDC/ONDIEH/NCIPC); Stout, Elly; calvin.stowell@thetrevorproject.org; AVactor@mhaofnyc.org; Warner, Margaret (CDC/OPHSS/NCHS); katherine.v.warrick.civ@mail.mil; kevin.wong@thetrevorproject.org; Wright, James (SAMHSA/DPTSSP)
Subject: Media Messaging Work Group Call
When: Thursday, June 7, 2018 11:00 AM-11:30 AM (UTC-05:00) Eastern Time (US & Canada).
Where: Phone Number: 866-370-2808 (access code (b)(6)
Phone Number: 866-370-2808 (access code (b)(6)
Email Context (From 5/14):
Hello Media Messaging Work Group (MMWG),
Following the email below, we wanted to let you know that the CDC data expected to be released on June 5 will **now be released on June 7**. Additionally, we received word that we will not be receiving an embargoed copy so we'll be rescheduling our MMWG group call (originally scheduled for Thursday, May 31) to **Thursday, June 7 at 11:00 a.m.**

The goal of this call is to convene our partners to: 1) discuss the data, and 2) develop consensus on our

messaging that will be used to craft a statement. If you are unable to join the call, you will still have the opportunity to weigh in on the statement via email.
We hope you can join us on Thursday, June 7 at 11:00 a.m.
Lastly, we want to thank CDC for giving us the heads up about the data.
Best,

Hello Media Messaging Work Group,
We wanted to call to your attention to a just-released article published in the *American Journal of Preventive Medicine* that looks at county-specific estimates of suicide rates. The paper titled "County-level Trends in Suicide Rates in the U.S., 2005-2015" was written by our Partner, CDC (authors include: Lauren M. Rossen, Holly Hedegaard, Diba Khan and Margaret Warner from NCHS).
Key findings include:

- Posterior predicted mean county-level suicide rates increased by >10% from 2005 to 2015 for 99% of counties in the U.S., with 87% of counties showing increases of >20%.
- Counties with the highest model-based suicide rates were consistently located across the western and northwestern U.S., with the exception of southern California and parts of Washington.
- Compared with more urban counties, more rural counties had the highest estimated suicide rates from 2005 to 2015, and also the largest increases over time.

Overall the data underscores the importance of looking at geographic areas to identify high risk and need for more coordinated and comprehensive community-based suicide prevention efforts in the U.S. While the Action Alliance does notplan to put out a formal statement about the data at this time, we encourage you to reference our past collective statement (written in collaboration with the MMWG partners) released last year that looks at suicide rates in urban and rural areas. You'll notice much of the information is very relevant and timely as it relates to the county-level trends data.
Please find below some tailorable social media posts to help further promote the data:

- Data released by @CDCInjury featured in @AmJPrevMed shows county-level trends in suicide rates in the US http://bit.ly/2IHo6hk
- New article featured in @AmJPrevMed underscores need for coordinated and comprehensive community-based suicide prevention efforts http://bit.ly/2IHo6hk
- Trends about suicide, like geographic patterns, helps us develop more targeted community-based #suicideprevention strategies http://bit.ly/2IHo6hk so we can reduce annual suicide rate 20% by 2025
- Rural counties in the U.S. had the highest estimated suicide rates from 2005-2015 according to just-released @AmJPrevMed http://bit.ly/2IHo6hk
- Tracking county-level suicide rates helps our field to better understand changes in suicide rates over time and develop more targeted suicide prevention efforts http://bit.ly/2IHo6hk
- Together we can reduce the annual suicide rate 20 percent by 2025 but we need continued research on community-level risk and protective factors as shown in recent data by @CDCinjury http://bit.ly/2IHo6hk

When posting, please consider incorporating Media Messaging Work Group Partner Twitter handles:

- @Action_Alliance
- @AASuicidology
- @afspnational
- @CDCInjury
- @CDCMMWR
- @DeptofDefense
- @DeptVetAffairs

- @EDCTweets
- @NIH
- @NIMHgov
- @ReingoldInc
- @samhsagov
- @SAVEvoicesofedu
- @SPRCtweets
- @TrevorProject
- @800273TALK

Some resources that you may also find helpful as you promote the data include:

- **Action Alliance's *Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention*** – A resource that outlines strategic components that should guide program planning and implementation at the community level.
- **CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*** – A resourcethat helps states and communities prioritize efforts to prevent suicide.

We wanted to give you all the heads up that CDC is also expected to release additional relevant data to inform suicide prevention efforts on or around June 5th. The Action Alliance Secretariat does plan to convene this group to develop consensus messaging around this impending data release. In preparation for this larger data release, we'll be convening the MMWG for a call in late May to discuss the data and our collective statement.

REQUEST: Please join us for a planning call on Thursday, May 31 at 2:00 p.m. ET to plan ahead for collective statement about CDC data.

We will send you a calendar invite (containing call-in information) to you shortly. If you are unable to participate on this call, you'll have the opportunity to weigh in on the statement electronically.

Lastly, we wanted to thank CDC for giving us the heads up about the data.

Thank you.

From: Sokler, Lynn (CDC/OD/OADC)
Sent: 6 Jun 2018 14:32:49 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Lenard, Courtney (CDC/ONDIEH/NCIPC);Dorigo, Leslie (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Simon, Thomas (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Gaines-McCollom, Molly (CDC/OPHPR/DEO);DeNoon, Daniel (CDC/OD/OADC) (CTR);Grusich, Katherina (Kate) (CDC/OD/OADC);Hoskins, Sharon (K.D.) (CDC/OD/OADC);Iverson, Dontae (CDC/OD/OADC);Balluz, Lina (ATSDR/DTHHS/OD);Bonds, Michelle E. (CDC/OD/OADC);Brand, Anstice M. (CDC/OD/CDCWO);Brown, Renee (CDC/ONDIEH/NCCDPHP);Bumpus, Stefanie (CDC/OID/NCEZID);Burden, Bernadette (CDC/OD/OADC);Burns, Annina (CDC/OD/CDCWO);Charles, Julia (CDC/OD/OCS);Clark, Cynthia K. (CDC/OD/OCS);Crawford, Carol Y. (CDC/OD/OADC);Daniel, Katherine Lyon (CDC/OD/OADC);Das, Mansi S. (CDC/OD/OADC);Dempsey, Jay H. (CDC/OD/OADC);Diaz, Shelly S. (CDC/OID/NCHHSTP);Dills, Kimberly C. (ATSDR/OPPE);DPAID (CDC);Dunn, Evelyn (CDC/OCOO/OFR/OA);Galatas, Kate (CDC/OD/OADC);Gonzalez, Belsie (CDC/OD/OADC);Grant, Llelwyn (CDC/OD/OADC);Green, Hugh (CDC/OD/OCS);Guest, Megan (CDC/OD/OADC);Heldman, Amy B. (CDC/OD/OADC);Hogg, Jarrad (CDC/OD/OADC);Hoo, Elizabeth (CDC/OD/PPEO);Iademarco, Michael (CDC/OPHSS/CSELS/OD);Joyner, Tonya (CDC/OSTLTS/OD) (CTR);Kelly, Alison (CDC/OCOO/OFR/OA);Kent, Charlotte (CDC/OPHSS/CSELS/DPHID);Knight, Dianna (CDC/OD/OADC);Knotts, Ashley (CDC/OD/OCS);Kroop, Seth (CDC/OD/OCS);Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD);Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD);McGowan, Robert (Kyle) (CDC/OD/OCS);Olivares, Dagny (CDC/OSTLTS/OD);Parikh, Sapana (CDC/OCOO/OFR/OA);Parker, Stacey M. (CDC/OSTLTS/OD) (CTR);Payne, Chelsea C. (CDC/OSTLTS/OD);Putman, Ami D. (CDC/OPHSS/CSELS/DLS);Rasmussen, Sonja (CDC/OID/OD);Redd, Stephen (CDC/OPHPR/OD);Redfield, Robert R. (CDC/OD);Schattner, Aimee (CDC/OD/CDCWO);Schindelar, Jessica (CDC/OD/OADC);Schuchat, Anne MD (CDC/OD);Simon, Gia M. (CDC/OSTLTS/OD);Smith, Patti (CDC/OD/OADC);Sokler, Lynn (CDC/OD/OADC);Sorrells, Marjorie J. (CDC/OD/OCS);Stanojevich, Joel G. (CDC/CGH/OD);Ware, Nina (CDC/OD/OADS);Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID);Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR);Wilson, Michelle (CDC/OCOO/OFR/OA)
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Subject: FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention
Attachments: DEAR COLLEAGUE_V2_5.15.18.13.02pm_rev_Final.DOCX, PRESS RELEASE_Suicide_VS_V6 _Final.docx, FACT SHEET_Vital Signs_June_2018_Suicide_Final_WEB.pdf, GRAPHIC_ PR_VS_June_2018_Suicide-Eng_v4_Final.pdf, TELEBRIEF SCRIPT_V6_06.6.18_206pm_pgmck_Final.docx, QA Document Suicide Vital Signs 6.5.18.docx, MMWR_Vital Signs_Suicide_6.7.2018_article.pdf

Hi Folks,

This month's issue of Vital Signs is on **Suicide Rates Rising across the U.S.** and releases **Thursday, June 7** with a Media Telebriefing at noon. **All materials go live on the CDC website at 1 pm**. Here are the key materials to use to distribute to stakeholders and partners: The Dear Colleague letter, MMWR, Fact Sheet, Press Release and Graphic.

For those distributing to media, please send the MMWR, Fact Sheet, Press Release and Graphic. Dr. Schuchat will be the primary spokesperson for this Vital Signs.

For those of you distributing out to partners and other constituents Thursday morning at 9 am, please make sure they know these are advance copies only. These materials are **embargoed until Thursday June 7 at 1 pm**. Please adjust the Dear Colleague letter for those people to which you send. Also please send Rich and me a copy when you email this out to your groups.

We will also have the press release on CDC en Espanol and available through the Vital Signs website.

For those attending the media telebriefing, I have also attached the Telebriefing Script and the Q&A document. **These do not get distributed externally.**

For each Vital Signs issue, we track and report on results **two times** – after 24 hours and after 30 days. We track the number of audiences reached (from all media and web sources), # of stories and type of media, the dollar value of the media coverage if CDC had to purchase it as advertising, social media use and reuse, and # of people looking at Vital Signs on our web pages.
Vital Signs reaches out to a lot of different people with our topics and, from our evaluation surveys, the uptake out in the field is impressive. In a survey, an astounding **95%** of state health officers and state epidemiologists were aware of and used VS issues, with about 3 in 4 using VS in the past year. All shared the material with their constituents via conference call, e-mail, newsletter, or mailing for topics appropriate to their members. A stratified random sample survey, used with NACCHO member organizations, reported that **74%** of all county or local health departments had heard of or used VS in the past year to educate staff, improve programs, and guide policy formation. As well, a 2017 internal evaluation showed that most program staff involved believe the value derived from it is worth the work, although producing Vital Signs takes a lot of effort.

I want to thank everyone who has worked on this issue for all their extra efforts. It's a very important topic and will be valuable information for many people. We hope that program continues to use this Vital Signs to promote its messages and the recommended actions in it to achieve new results.

Cheers,
Lynn

Lynn A. Sokler|Senior Communication Advisor|Office of the Director|Office of the Associate Director for Communication| Centers for Disease Control and Prevention|Mailing: 1600 Clifton Road MS-E-69| Atlanta, GA 30329| zszo@cdc.gov| office 404-498-6617 |bus. cell 404-409-5556|fx 404-498-0945



Dear Colleague:

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Tuesday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Web page to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Thank you for your support.

Debra Houry, MD, MPH
Director
National Center for Injury Prevention and Control

James A. Mercy, PhD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control

Press Release
Embargoed until 1:00 pm ET
Thursday, June 7, 2018
Contact: CDC Media Relations
404-639-3286

Suicide rates rising across the U.S.

Comprehensive prevention goes beyond a focus on mental health concerns

Suicide rates have been rising in nearly every state, according to the latest *Vital Signs* report by the Centers for Disease Control and Prevention (CDC).

In 2016, nearly 45,000 Americans age 10 or older died by suicide. Suicide is the 10th leading cause of death and is one of just three leading causes that are on the rise.

Suicide is rarely caused by a single factor. Although suicide prevention efforts largely focus on identifying and providing treatment for people with mental health conditions, there are many additional opportunities for prevention.

"Suicide is a leading cause of death for Americans – and it's a tragedy for families and communities across the country," said CDC Principal Deputy Director Anne Schuchat, M.D. "From individuals and communities to employers and healthcare professionals, everyone can play a role in efforts to help save lives and reverse this troubling rise in suicide."

Many factors contribute to suicide

For this *Vital Signs* report, CDC researchers examined state-level trends in suicide rates from 1999-2016. In addition, they used 2015 data from CDC's National Violent Death Reporting System, which covered 27 states, to look at the circumstances of suicide among people with and without known mental health conditions.

Researchers found that more than half of people who died by suicide did *not* have a known diagnosed mental health condition at the time of death. Relationship problems or loss, substance misuse; physical health problems; and job, money, legal or housing stress often contributed to risk for suicide. Firearms were the most common method of suicide used by those with and without a known diagnosed mental health condition.

State suicide rates vary widely

The most recent overall suicide rates (2014-2016) varied four-fold; from 6.9 per 100,000 residents per year in Washington, D.C. to 29.2 per 100,000 residents in Montana.

Across the study period, rates increased in nearly all states. Percentage increases in suicide rates ranged from just under 6 percent in Delaware to over 57 percent in North Dakota. Twenty-five states had suicide rate increases of more than 30 percent.

Wide range of prevention activities needed

The report recommends that states take a comprehensive public health approach to suicide prevention and address the range of factors contributing to suicide. This requires coordination and cooperation from every sector of society: government, public health, healthcare, employers, education, media and community organizations.

To help states with this important work, in 2017 CDC released a technical package on suicide prevention that describes strategies and approaches based on the best available evidence. This can help inform states and communities as they make decisions about prevention activities and priorities.

Everyone can help prevent suicide:

- Learn the warning signs of suicide to identify and appropriately respond to people at risk. Find out how this can save a life by visiting: www.BeThe1to.com
- Reduce access to lethal means – such as medications and firearms – among people at risk of suicide.
- Contact the National Suicide Prevention Lifeline for help: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org

The media can avoid increasing risk when reporting on suicide by:

- Following and sharing recommendations available at www.reportingonsuicide.org (for example, avoiding dramatic headlines or explicit details on suicide methods);
- Providing information on suicide warning signs and suicide prevention resources; and
- Sharing stories of hope and healing.

Vital Signs is a CDC report that typically appears on the first Tuesday of the month as part of the CDC journal *Morbidity and Mortality Weekly Report*. The report provides the latest data and information on key health indicators, and what can be done to drive down these health threats.

###

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than a mental health concern

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as those related to relationships, substance use, physical health, and job, money, legal, or housing stress. Making sure government, public health, healthcare, employers, education, the media and community organizations are working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



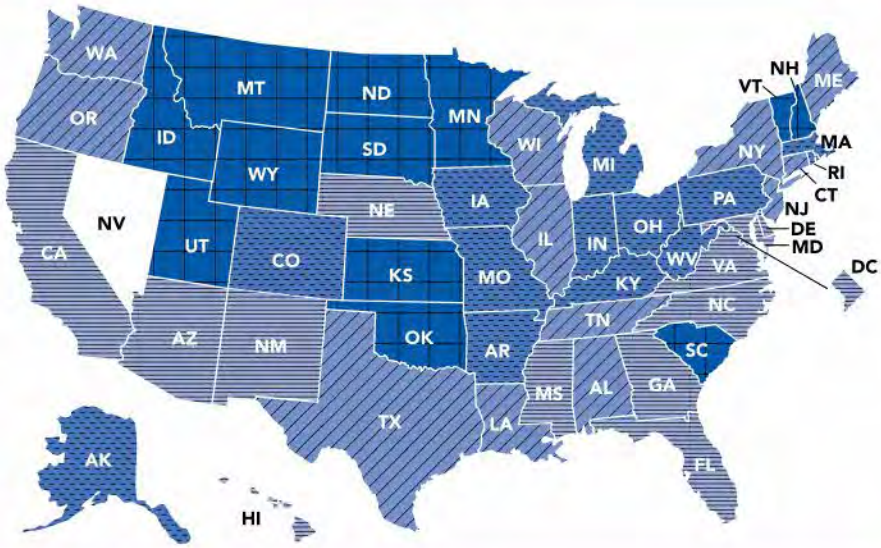
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*

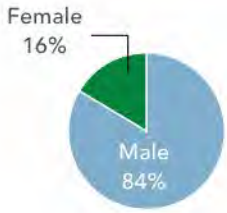


Differences exist among those with and without mental health conditions.

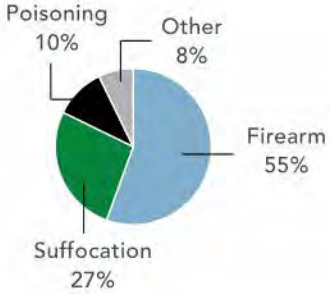
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions

Sex

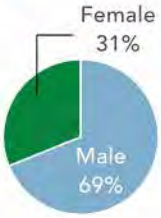


Method

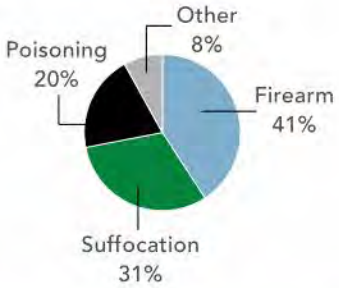


Known mental health conditions

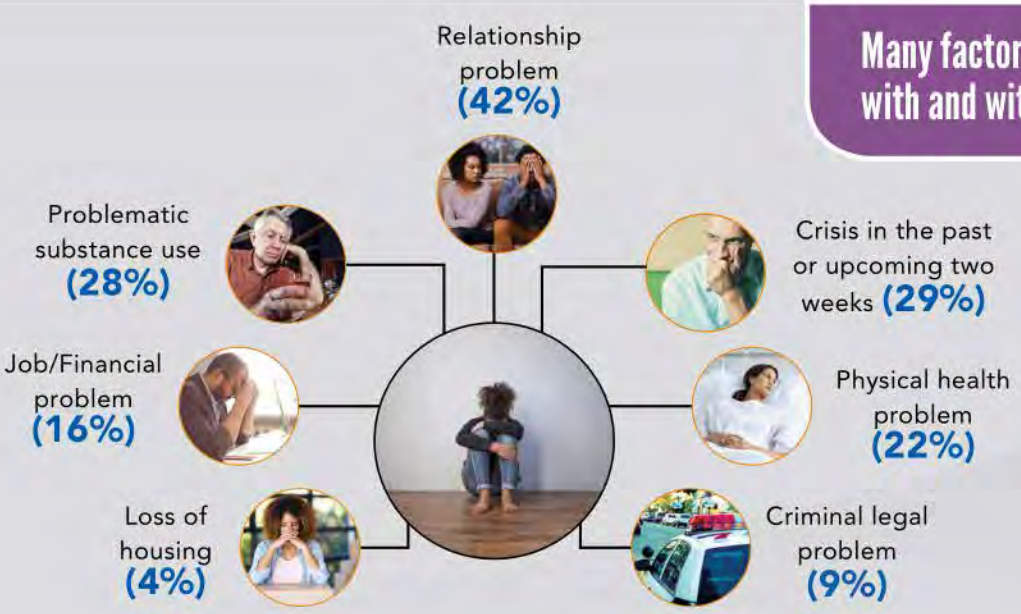
Sex



Method



Many factors contribute to suicide among those with and without known mental health conditions.



Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing suicide involves everyone in the community.

Provide financial support to individuals in need.

States can help ease unemployment and housing stress by providing temporary help.

Strengthen access to and delivery of care.

Health care systems can offer treatment options by phone or online where services are not widely available.

Create protective environments.

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect people within their communities.

Communities can offer programs and events to increase a sense of belonging among residents.

Teach coping and problem-solving skills.

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent future risk.

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and support people at risk.

Everyone can learn the warning signs for suicide, how to respond, and where to get help.

Know the Suicide WARNING SIGNS

- Feeling like a burden
- Being isolated

- Increased anxiety
- Feeling trapped or in unbearable pain

- Increased substance use
- Looking for a way to access lethal means

- Increased anger or rage
- Extreme mood swings

- Expressing hopelessness
- Sleeping too little or too much

- Talking or posting about wanting to die
- Making plans for suicide

5 STEPS TO HELP SOMEONE AT RISK

1. Ask.
2. Keep them safe.
3. Be there.
4. Help them connect.
5. Follow up.

Find out why this can save a life by visiting:
www.BeThe1To.com

SOURCE: www.BeThe1To.com

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing, implementing, and evaluating suicide prevention strategies.
- Supporting local, state, tribal, national, and other partners to prevent suicide (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.

HEALTH CARE SYSTEMS CAN

- Provide high-quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help, and provide referrals to mental health, substance use, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support. You can start with the Lifeline (1-800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.BeThe1To.com.

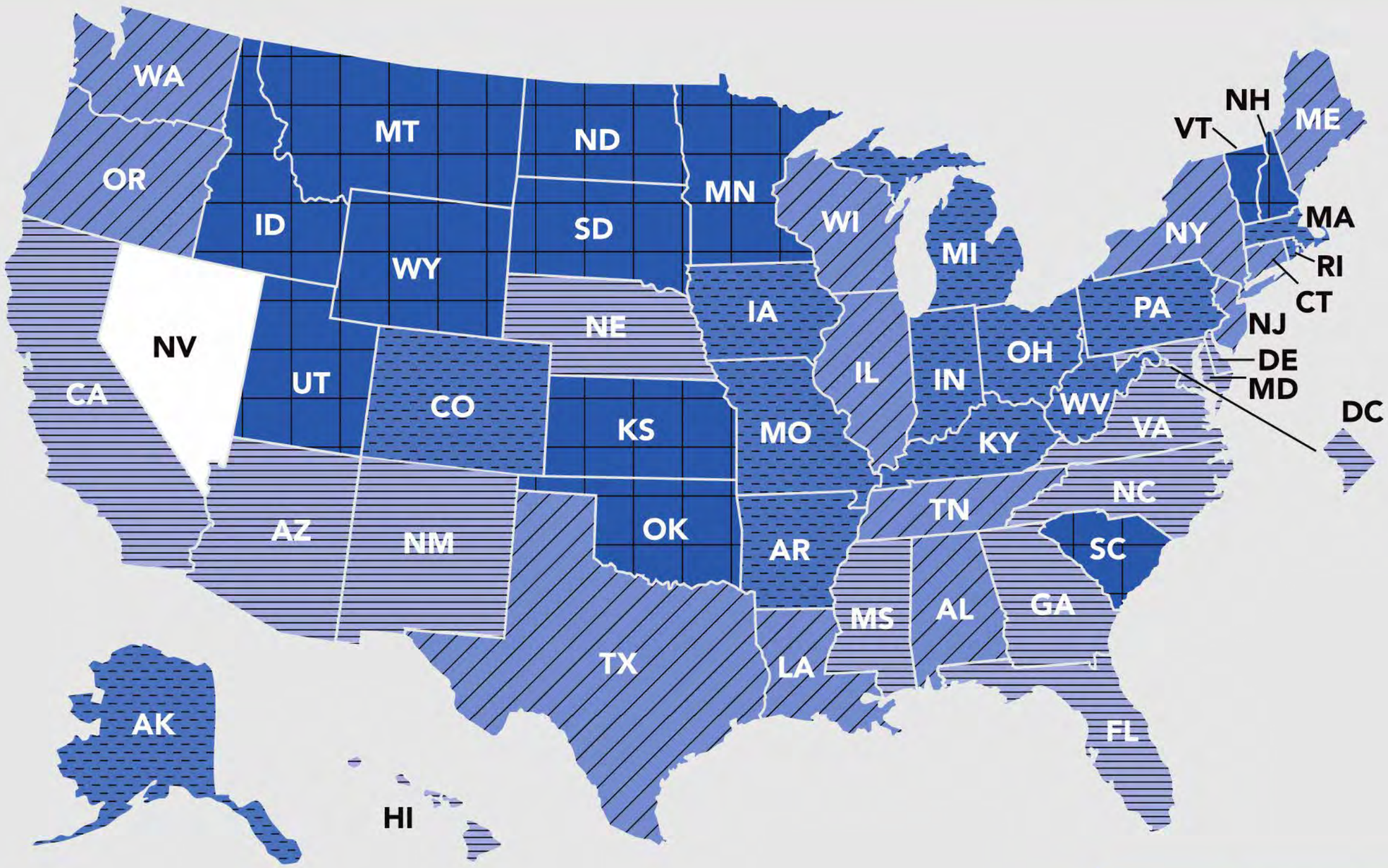
The media can avoid increasing suicide risk (e.g., by not using dramatic headlines or providing explicit details) and encourage people to seek help.
View recommendations at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018

Suicide rates rose across the US from 1999 to 2016.



SOURCE: *CDC's National Vital Statistics System.*

CDC Vitalsigns™

https://www.cdc.gov/vitalsigns/suicide

CS292322-C

Vital Signs Rising Suicide Rates Across U.S.

June 7, 2018

Desired Headlines

- Nearly 45,000 lives lost to suicide in 2016, but suicide is preventable.
- Suicide rates up in almost all states, but suicide is preventable.
- Suicide rates went up more than 30% in half of U.S. states between 1999 and 2016.
- Many factors contribute to suicide, beyond mental health conditions alone.

Moderator: Thank you (OPERATOR NAME). And thank you all for joining us today for the release of a new CDC Vital Signs report on Trends in Suicide Rates and contributing circumstances to suicide. We are joined by Dr. Anne Schuchat, CDC's Principal Deputy Director and Dr. Deb Stone, lead author of the study. Following opening remarks, Drs. Schuchat and Stone will respond to questions. I'll turn the call over now to Dr. Anne Schuchat.

Dr. Schuchat:

- Good afternoon and thank you for joining us today.
- CDC works 24/7 to protect Americans against health threats. Each month in CDC's *Vital Signs* report, **we focus on one of these threats – and what can be done about it**.

- Today's report contains **new information about state suicide trends, the factors that contribute to suicide, and the implications for prevention.**
- In 2016 alone, **45,000 people in the U.S. lost their lives to suicide.**
- Unfortunately, our data show that the problem is getting worse.
- Suicide is one of just three leading causes of death that are on the rise.
- And these statistics don't begin to reveal the emotional, social and financial toll that suicide exacts on individuals, families and communities who are left devastated.
- Many of us have lost friends, neighbors and family members to suicide – or have loved ones who have considered or attempted it.
- **Between 1999 and 2016, suicide rates increased among all age groups** younger than 75 years. During that period, middle-aged adults had the largest number of suicides and particularly high increases in rates.
- We found that **suicide rates increased in nearly every state** across the nation.
- **These findings are disturbing. Suicide is a public health problem that can be prevented.**
- For this *Vital Signs* report, we first analyzed data from the National Vital Statistics System to look at trends in suicide rates for all 50 states and Washington, D.C.
- We then looked at data from CDC's National Violent Death Reporting System (the NVDRS), which included information for 27 states in 2015, and looked at

circumstances around suicides among people with and without known mental health conditions.

  - [As a side note, CDC is now collecting data in 40 states, D.C. and Puerto Rico. And Congress has provided additional funding in the fiscal year 2018 omnibus so that CDC can expand the system to all 50 states].

- **Suicide is often attributed solely to a mental health concern. But, according to our data (NVDRS), fewer than half of the people who died by suicide had a known mental health condition.**
- Our research found that those people who died by suicide and ***did not*** have a diagnosed mental health condition were somewhat more likely than those *with* a mental health condition to struggle with **relationship problems or loss, other life stressors,** and experience **recent or impending crises**. However, and importantly, these circumstances were likely to occur in all people who died by suicide, regardless of whether or not they had a diagnosed mental health condition.
- **Suicide IS preventable.**
- That's why it's so important to understand the range of factors and circumstances that contribute to suicide risk, including **relationship problems, substance misuse, physical and mental health conditions, job issues, financial troubles, and legal problems.**

- With this information in mind, states and communities can develop a comprehensive approach to suicide prevention. One example of a successful program is **The United States Air Force Suicide Prevention Program**. This program, (which includes 11 policy and education initiatives designed to increase social support, social skills, and help-seeking) shifted the culture of the Air Force away from viewing suicide as an individual-oriented mental health concern to a larger, service-wide problem impacting the whole community. After the program was begun, the Air Force saw a 33% reduction in suicide as well as reductions in other related problems, such as severe family violence (54%) and homicide (51%).
- By increasing **awareness of the range of circumstances** contributing to suicide risk, and acting to address them through a comprehensive approach, we could reach our national goal of **reducing the annual suicide rate by 20 percent by 2025**.
- Today's report suggests we have a lot of important work to do to reach this goal. Nearly **all states had increasing suicide rates between 1999 and 2016, and 25 states had rate increases of more than 30 percent.**
- So how do we work together to reverse these numbers and help save lives?
- **On the Federal level, government agencies are tracking the problem of suicide to understand trends and groups at greatest risk;** developing, implementing, and

evaluating what works to prevent suicide in communities; supporting local, territorial, state, tribal, and other partners to prevent suicide; and working with public and private partners to advance the **National Strategy for Suicide Prevention.**

- In states and communities, close coordination of activities between public health agencies and other sectors of society is critical for preventing suicide. Necessary partners include health and mental healthcare providers, social services, first responders, educators, faith communities, and the media.
- States and communities ***can*** **and** ***should*** **take action now**.
- To help prioritize prevention, CDC developed *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* It features the best available evidence for states and communities to guide their prevention activities.
- Some of the strategies are designed to prevent suicide risk before it emerges in the first place. These strategies include teaching coping and problem-solving skills to help people manage life challenges; promoting safe and supportive environments, including safe storage of medications and firearms among people at risk; providing temporary help for people struggling to make ends meet; and encouraging connectedness so people are less likely to feel alone or isolated.

- Other strategies in the technical package are designed to support people who may already be struggling, by providing effective treatment and crisis intervention strategies.

- Health and behavioral health care providers have an important role to play in suicide prevention as well, so that nobody in these systems falls through the cracks. Policies and protocols that prioritize patient safety and that help get people into ongoing care, especially during care transitions, can help prevent suicide.

- Last and very important, the technical package describes approaches to prevent future suicide risk among people who have attempted suicide or have lost a friend or loved one to suicide.

- You can find the link to the technical package is on our *Vital Signs* website.
- **Preventing suicide takes everyone. Parents, employers, teachers, coaches, religious leaders, healthcare providers, and people affected by suicide – everyone in the community** can help prevent suicide risk by learning the warning signs of suicide and how best to respond effectively. **Together we can work to bring hope and save lives.**

Suicide Prevention Vital Signs Q&As

For internal use only.

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General Background on the Problem of Suicide

- **Suicide is a public health problem.**
  - Nearly 45,000 lives were lost to suicide in 2016, which is approximately one suicide every 12 minutes.
  - Rates have increased by nearly 30% from 1999-2016 (28.1%)
  - Suicide rates vary by race/ethnicity, age, and other population characteristics, with the highest rates across the lifespan occurring among non-Hispanic American Indian/Alaska Native (AI/AN) and non-Hispanic White population groups, middle-aged adults, veterans and active duty personnel, certain occupational groups, and sexual minority youth.
  - More than half of suicide deaths occur among adults in the prime of their lives, ages 35-64.
  - Suicide rates in rural areas are consistently higher than rates in more urban areas.
  - Suicide and nonfatal self-harm injuries cost more than $69 billion annually in direct medical and work loss costs.

- Decades of research have shown that suicide is preventable.

What was the impetus for this study?

1. What was the impetus for this study?

The CDC has a strong portfolio of research describing the increasing trends in suicide as well as rich data on circumstances contributing to suicide from the National Violent Death Reporting System. CDC also has a technical package geared towards states and communities that provides what works to prevent suicide based on the best available evidence.

With all of this information in hand and in the context of increasing national suicide rates, the present study was motivated to support states and our nation as we seek to meet the national goal of reducing annual suicide rates 20% by 2025.

2. A CDC employee went missing in February and was later found deceased. His death was determined to be suicide. Is that why you're publishing this study now?

The CDC community continues to be deeply saddened and impacted by the death of Commander Cunningham. As you correctly state, his death was recently ruled a suicide by the Medical Examiner's office. While it's true the timing of our study is close to Commander Cunnigham's death, this study began many months before Commander Cunningham disappeared.

CDC has worked to prevent suicide for many years and suicide prevention is currently a priority area. We have a strong portfolio of research describing the increasing trends in suicide and rich data on circumstances contributing to suicide from the National Violent Death Reporting System. CDC also has a technical package geared towards states and communities that provides what works to prevent suicide based on the best available evidence.

With all of this information in hand and in the context of increasing national suicide rates, the present study was motivated to support states and our nation as we seek to meet the national goal of reducing annual suicide rates 20% by 2025.

What is CDC doing to prevent suicide?

3. Has CDC provided states resources to prevent suicide? Who in the state does this work?

CDC does not provide direct funding to states to conduct suicide prevention work specifically, as CDC has no appropriation for suicide prevention.

However, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides grants to states, tribal communities, and campuses through its Garrett Lee Smith, National Strategy, and Zero Suicide grant programs.

CDC funds 23 state health departments through the Core State Violence and Injury Prevention Program, which helps states implement, evaluate, and disseminate strategies to prevent injuries and violence. Some of the states funded under this initiative are focusing their efforts on suicide prevention.

The CDC also funds ten Injury Control Research Centers (ICRCs). These centers study ways to prevent injuries and violence and work with community partners to put research findings into action. Four of the currently funded ICRCs are working to prevent suicide through research, training, or outreach activities: University of Iowa, University of North Carolina at Chapel Hill, University of Rochester, and West Virginia University.

CDC has also created a technical package for suicide prevention that states and communities can use to inform and guide their prevention efforts.

4. What is CDC doing to prevent suicide?

The CDC takes a public health approach to preventing suicide, which involves a number of steps. CDC is:

- **Tracking and monitoring trends** in suicide and suicide attempts to inform prevention policies and programs (for example--)
    - Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. MMWR Morb Mortal Wkly Rep 2018;67:237–242.
- **Identifying risk and protective factors**; and developing evidence-based prevention programs.
    - **Developing an environmental scan of all 50 states, D.C., territories, and select tribes (STTs)** to gain a greater understanding of what factors at the STT-level may be associated with rising suicide rates (e.g. lack of suicide prevention infrastructure, prevention activities, legislation passed, partnerships/collaborations, barriers & facilitators to suicide prevention).
- **Evaluating programs**, policies, practices to determine if they prevent suicide risk.
    - **Currently evaluating two RCTs** with interventions focused on middle-aged males. These projects are in year 3 of 4 currently so results are not yet available. One project uses a multi-media program in the waiting room to help men at high-risk to raise their suicidal thoughts with their primary care clinicians. The second project evaluates the impact of mantherapy (www.mantherapy.org), an intervention designed specifically males that uses humor and male stereotypes to get across messages on suicide prevention, plus screening for mental health resources compared to just screening for mental health resources
- **Sharing information about the best available evidence** (for example, the suicide prevention technical package).

New projects (Also included on page 32-33)

- **Linking NVDRS with Departments of Defense and Veterans Affairs data on suicide**

- Partners who are working on this project include Department of Veterans Affairs, Department of Defense Suicide Prevention Office, and the Psychological Health Center of Excellence/Defense Health Agency.
- This project will link pertinent data on active duty Military and Veteran suicide decedents across CDC's National Violent Death Reporting System (NDVRS), the Department of Defense Suicide Event Reports, and the Veteran Health Administrative databases.
- Provide more information on suicides among active duty Military personnel and Veterans as well as partition study populations in the NVDRS (e.g., civilians, active duty, VHA Veterans, non-VHA Veterans).
- Help agencies monitor common and unique precipitating factors of suicide captured in NVDRS by group/population and inform comprehensive community-based efforts to help address specific population needs. All linkages will use a de-identified matching technique. No personal identifying information will be used.

- **Social media intervention**
  - The purpose of this project is to implement, test, and refine a web-based peer-to-peer therapeutic support platform for U.S. Military Veterans aimed at preventing suicide and related problems.
  - This system called TalkVet, has the potential to bridge the gap between the many social media sites that are widely used by Veterans (e.g., Facebook, Snapchat, etc.) and the growing number of clinical interventions that are available to Veterans, but currently under-utilized.
  - With the explicit consent of users, we will test the novel features of the TalkVet platform in three ways:
    1. Use an artificial intelligence (AI) guided system to help identify participating Veterans most in need of help based on their posts and other user activity;
    2. Connect Veterans in need of help with other Veterans in TalkVet who can support them; and
    3. Conduct outreach with experimentally refined methods for Veterans in need of a higher level of care to encourage them to obtain such care in the form of links and hand-offs provided by the TalkVet system (this phase of the work will include the use of Veteran moderators with training in crisis counseling who will work with our team).
  - This project includes partners from Harvard University, West Virginia University ICRC, TalkLife/Talk/Vet and has been approved by CDC-F.

- **Colorado Collaborative for a Comprehensive Approach to Suicide Prevention**
  - The CDC is collaborating with the Colorado Department of Public Health and Environment, the CDC-funded Injury Control Research Center (ICRC-S), the Colorado National Collaborative (CNC), and the Colorado Suicide Prevention Commission on the first state-wide, large-scale, population-based initiative to reduce suicide rates 20% by 2024 in CO and to serve as a model for other states to help reduce suicide by 20% by 2025 in the nation. Partners on the CNC also include the Action Alliance, SAMHSA, and AFSP, among others.
  - Through this project we propose to pilot test the implementation and evaluation of a comprehensive, integrated approach to suicide prevention—guided, in part, by the CDC's technical package and the National Action Alliance for Suicide Prevention's (NAASP) *Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention*.
  - Working with CDC/F to seek external funding
  - Why Colorado?
    - Colorado consistently ranks among the states with the highest suicide rates in the nation (rate: 19.5 per 100,000 in 2015—U.S. rate 13.3 per 100,000).

- Colorado has sizable populations at increased risk of suicide, including veterans, American Indian/Alaska Natives (AI/AN), and people living in rural communities.
- Colorado demonstrates readiness as evidenced by a strong state suicide prevention infrastructure, a history of political will, and a proven track record of valuing and implementing public health approaches to prevention. Specifically, the State has:
    - A funded Office of Suicide Prevention (OSP; legislated in 2000)
    - Suicide Prevention Commission (legislated in 2014)
    - Colorado National Collaborative (est. 2015)
    - A strong platform of existing suicide prevention activity
    - A commitment to 'connecting the dots'/shared risk and protective factors

*The CDC Foundation is seeking funds from donors to support this work. It is also partially funded by a grant from SAMHSA and other state and local resources (to a small degree).

Why are suicide rates increasing?

5. Why are suicide rates increasing?

While the Vital Statistics data are great for describing trends they don't tell us about the causal factors that are driving the increases.

We do know that suicide is not caused by one factor, but instead, it is typically caused by a combination of individual, relationship, community, and societal factors.

Several such factors could be contributing to the increases:

Economic conditions

The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability could have contributed to increases in suicide risk. Past research on the association between business cycles and U.S. suicide rates indicates that the overall suicide rate rises and falls in connection with the economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.

Opioid epidemic

Increased availability and misuse of prescription opioids may be related to increases in suicide rates. Substance misuse itself is an established risk factor for suicide and, therefore, opioid misuse associated with the opioid overdose epidemic could be driving the suicide rate higher. When we look at who is dying from suicide and who is dying from unintentional overdoses involving opioids, we see that there is overlap in the demographics of the populations most highly affected by suicide and unintended opioid overdose deaths. Data also indicate that opioid prescribing rates are higher in counties where there are higher rates of suicide.

Social media

More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

Rural

While there have been increases and decreases in rates over time, research shows that rates across cities and towns in the United States have been rising, with rural areas experiencing the most increases. The increased rates may be associated with suicide risk factors that are more common in less urban areas, such as limited access to mental healthcare as well as greater social isolation.

Bridge to:

Although the reasons for the increases in suicide rates are not fully understood, we do know a lot about the circumstances that contribute to suicide risk. It is clear that many factors contribute to suicide beyond mental health factors alone.

- These factors include such things as relationship problems (e.g. relationship loss through death, divorce, or break-up; arguments, interpersonal violence), problematic substance, physical health problems, job/financial problems, and legal problems.

6. Why are suicide rates increasing so much in Western states?

Suicide rates have consistently been higher in Western states and these data show that several Western states have seen substantial increases in suicide rates. While the reasons for this need additional study, research has shown that suicide rates have increased faster in rural areas, which may explain some of the difference. Also, the timing of the increase seems to coincide with the Great Recession. Though the recession is over, rural areas were disproportionately impacted and have had a slower recovery time. Others have also pointed to social isolation and access to mental and behavioral health treatment as potential contributing factors to the higher suicide rates in Western states.

7. Why are suicide rates increasing more in less urban (or more rural) areas?

While there have been increases and decreases in rates over time, research shows that rates across cities and towns in the United States have been rising, with <u>rural areas experiencing the greatest increases</u>.

- **Increased rates may be associated with suicide risk factors that are more common in less urban areas**,
  - Limited access to mental healthcare
  - Greater social isolation.

        - **Loss of jobs, homes, and income associated with the Great Recession as well as the prescription opioid overdose epidemic**, which has had a greater impact on less urban areas.
    - Urban areas may also experience these risk factors, but to a lesser extent.

8. During the Great Recession, there was an increase in suicide, but why are rates still going up since the economy has bounced back?

Suicide rates have continued to rise after the Great Recession.

A previous study found that suicide rates across all urbanization levels in the U.S. increased over the period from 1999-2015, but the gap in rates between less urban and more urban areas widened over this period, and rates in more rural areas increased at a more rapid pace than more urban areas beginning in 2007-2008.

The rapid acceleration of increasing suicide rates in more rural areas in 2007-2008 may reflect the corresponding start of the Great Recession at about this same time.

- **The disproportionate impact of the recession on rural areas and the longer economic recovery time in these areas may help to explain why suicide rates have remained high overall.**
- Other common suicide risk factors including mental health and substance use problems may be exacerbated in rural areas potentially influenced by the prescription opioid overdose epidemic , poor access to mental healthcare, made worse by shortages in behavioral health care providers in rural areas, and greater social isolation in rural areas.

The potential cumulative burden of suicide risk factors in less urban areas may impact not only individuals but relationships, families, and communities as well, suggesting the need for comprehensive suicide prevention measures.

9. Is the opioid overdose epidemic associated with rises in suicide rates?

Both suicide and drug overdoses are on the rise. CDC is actively working to analyze and better understand the trends and risk factors for opioid overdose and suicide, and the connections between the two public health challenges.

Increased availability and misuse of opioids may be related to increases in suicide rates. Substance misuse itself is an established risk factor for suicide and, therefore, opioid misuse associated with the opioid overdose epidemic could be driving the suicide rate higher. When we look at who is dying from suicide and who is dying from unintentional overdoses involving opioids, we see that there is overlap in the demographics of the populations most highly affected by suicide and unintended opioid overdose deaths. Data also indicate that opioid prescribing rates are higher in counties where there are higher rates of suicide.

CDC uses several systems to monitor overdoses, overdose deaths & suicide:

- Deaths – Death certificates, National Violent Death Reporting System (NVDRS) and State Unintentional Drug Overdose Reporting System (SUDORS)
- Nonfatal – National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP), Healthcare Cost and Utilization Project from AHRQ, and emergency department syndromic/medical claims and EMS surveillance data from CDC's Enhanced State Opioid Overdose Surveillance program

10. Why are suicide rates increasing more among females?

This study showed that suicide rates were increasing for females and males. The increases for females were significant in 43 states and the increases for males were significant in 34 states. It is important to note that while the relative increases in rates were higher for females than for males overall, the absolute suicide rates rose faster for males than females. Male suicide rates are consistently 3 to 5 times higher than the suicide rates for females. It is important for suicide prevention strategies to address the needs of males and females.

While the Vital Statistics data can be used to describe such trends, these data cannot tell us about the causal factors that are driving the increases. We do know that suicide is not caused by one factor, but instead, it is typically caused by a combination of individual, relationship, community, and societal factors.

11. A paper came out recently about county-level trends in suicide rates in the US from 2005-2015, how do the results of that study compare with the results from the Vital Signs?

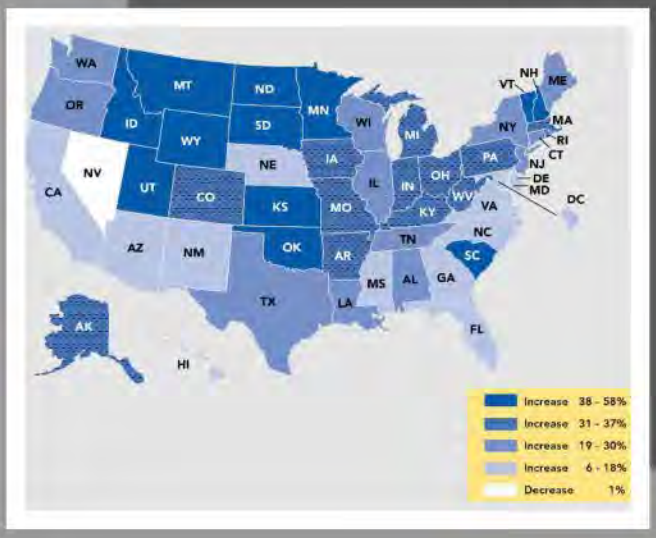
That paper and the VS both look at trends in suicide rates over time, however, this month's VS examines state-level trends in suicide rates whereas the other examines county-level trends. Despite this difference in the level of analysis undertaken (state vs county), both articles point to the same sobering conclusion that rates of suicide at both the state and county level have increased. States may use both sets of findings to tailor comprehensive suicide prevention to areas most impacted by suicide. CDC's technical package inclusive of the best available evidence to prevent suicide is an important resource that can benefit both states and local communities.

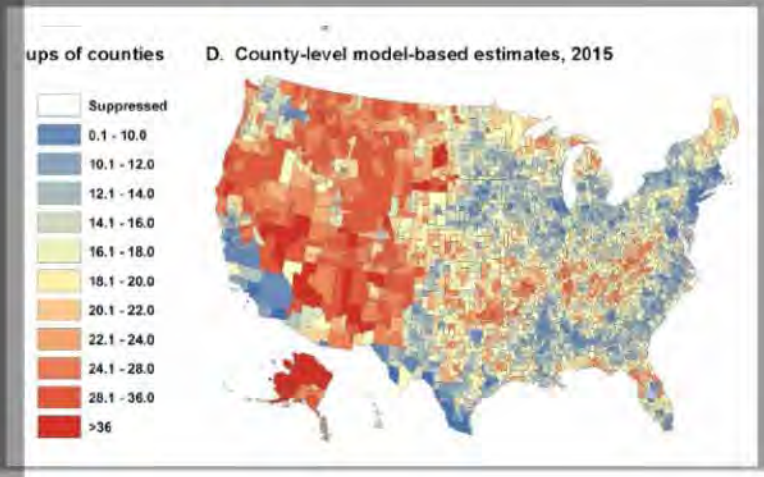
Note: Some counties with the highest and lowest rates of suicide do not align with our map, and in some cases, they contradict each other. This is because our map shows *percentage increases* in suicide rates over time at the state level vs. aggregated average rates of suicide over time at the county level as presented in the study by Rossen and colleagues.

County level suicide prevention paper (Rossen et al., 2018) compared to VS

	County paper	VS
Dates for analysis	2005-2015	1999-2016

Level of analysis	County	State
Increases in suicide rates	>10% for 99% of counties >20% in 87% of counties >30% in 34% of counties	Average 25.4% across states Range 6-58% increases >30% increase in half of states
Regions of highest increase	West and Northwest	Western states/Midwest
Rural vs Urban	Rural has highest rates	Didn't analyze
Rates	4.76 to 64.16	
Highest rates	Counties in AK, AZ, CA, CO, **ID,** MT, NM, NV, **ND, SD**, OR, **WY**	**ND**, VT, NH, UT, KS, **SD**, **ID,** MN, **WY**, SC
Lowest rates	Counties in **CA**, CT, MA, NY, RI, NJ, TX, **NC**, SC	DE, MD, FL, **NC, CA**, DC, GA, NE, AZ, VA, MS





12. Are part of the increases in suicide rates being driven, or impacted, by cases of physician assisted-suicide?

No. The suicide rates increases observed in this study are not related to cases of physician-assisted suicide. Physician-assisted suicide is currently legal in just a handful of states and such deaths are not classified as suicide.

13. Does CDC endorse or support physician-assisted suicide?

CDC does not take a stand, either for or against, physician-assisted suicide.

What's going on globally with respect to suicide rates?

14. How does the U.S. compare to other nations with respect to trends in suicide rates?

Globally, suicide rates have been declining.

Global data from the World Health Organization indicates that nearly all European societies experienced rising suicide rates after the Great Recession. However, unlike the U.S., the suicide rate in many European nations stabilized or returned to pre-recession levels after the recession. This may be because the economic recession impacted different countries in different ways, and areas within the U.S. may have taken longer to recover from the recession.

Although suicide rates also increased in Canada during the Great Recession, Canada has experienced a fairly level suicide rate over the past 17 years, with a rate between 12.5 to 13.0 per 100,000.

Unlike in the U.S., ingestion of pesticide is one of the most common methods of suicide globally. Policies related to the sales and import of pesticides, which have reduced access to this lethal means of suicide, have demonstrated impact in preventing suicide in some countries. For instance, in Sri Lanka, the suicide rate decreased from 47 per 100,000 in 1995 to 30.9 per 100,000 in 2005 after the implementation of such policies.

15. What's going on in the U.S. that's not occurring in other countries to explain the increase in suicide rates here?

The U.S. has good surveillance systems in place to track mortality, allowing us to identify the increases in suicide rates and even which areas of the country, age groups, and racial/ethnic groups are most at risk. Unfortunately, these surveillance systems do not assess and track the risk factors that may be contributing to these trends.

We know that ***suicide rates are increasing in most age groups and demographic groups and we are seeing increases across suicide methods***.

The increases in suicide rates are unlikely to be due to any single factor. Factors at the individual, relationship, and community levels - such as a prior suicide attempt, age; substance abuse history; school, job, or legal problems; exposure to another person's suicidal behavior; and the accessibility of assistance in the community all contribute to risk.

It is likely that multiple factors are influencing suicide trends.

16. Last year, Hurricanes Irma and Maria caused a great deal of both distress and fatalities in PR. Do we know how many of these deaths were suicide? How can we prevent these in the future?

Final data from Puerto Rico on the number of suicides is not yet available. CDC is collaborating with the Commission for Suicide Prevention at the Puerto Rico Department of Health in an effort to prevent suicide, increase awareness about factors that increase and decrease suicide risk, and to conduct training of healthcare providers and others in the community. CDC is also translating Preventing Suicide: A Technical Package of Policy, Programs, and Practices into Spanish. This document helps communities to prioritize prevention activities based on the best available evidence.

Firearms and Suicide

17. Are firearms a major means of suicide globally?

Unlike in the U.S., ingestion of pesticide and hanging are the two most common methods of suicide globally.

Policies related to the sales and import of pesticides, which have reduced access to this lethal means of suicide, have demonstrated impact in preventing suicide in some countries. For instance, in Sri Lanka, the suicide rate decreased from 47 per 100,000 in 1995 to 30.9 per 100,000 in 2005 after the implementation of such policies.

18. How many lives are lost to firearm-related suicides per year?

In 2016, almost 23,000 lives were lost due to suicides by firearm. This equates to 51% of suicides in the U.S. in 2016.

19. Does the CDC want to restrict access to firearms?

The CDC is *not* suggesting that firearms should be taken away from U.S. residents.

An important function of public health is to prevent injury and death. Given the lethality of firearms, it is important to identify ways to prevent them from being used for self-harm. Based on prior research, **we know that safe storage practices can help reduce the risk for suicide by separating people at-risk, or who have made prior attempts, from easy access to lethal means.** This can involve safely storing firearms locked and unloaded in a secure place (e.g., gun safe or lock box) and separate from ammunition. This can help to provide a buffer for those who are thinking about suicide and increases the time it takes them to access lethal means. **We know from prior research that simply providing a buffer in this critical time period can help reduce risk.**

20. What are the leading ways that people die by suicide?

Firearms are the mechanism for about half of all suicides in the United States.

The next leading methods are suffocation and poisoning.

Reducing access to lethal means of suicide among persons at risk for suicide is an intervention with robust supporting evidence; such intervention includes:

- Intervening at suicide hotspots such as bridges
- Counseling around safe storage of medications, firearms, or other household products to keep them away from people at risk.
- **These interventions can be combined with other strategies for a comprehensive approach to prevention.**

21. What was the process of obtaining support and resources from the CDC to do this research, given the agency's historical lack of funding for gun violence research?

This study used data from existing public health surveillance systems that collect data on many different causes of injury and death. CDC has, and continues to, support surveillance activities and analyses of surveillance and other data to document the public health burden of firearm injuries in the U.S. Understanding the patterns, characteristics, and impacts of firearm-related injuries is an important step toward prevention.

22. A previous report shows that a substantial number of gun-caused deaths are suicides. What could drive children to take their own lives and how do they access firearms in the first place?

When looking at the circumstances surrounding child firearm suicides, while mental health factors are important, firearm suicides are also frequently related to situational life stressors and relationship problems with an intimate partner, friend, or family member. It is important for parents and other adults who interact with children to be aware that life stressors such as these can have a big impact on children and put them at risk for suicide.

Other researchers have found that safe storage of firearms (storing firearms locked, unloaded, and separate from ammunition) is associated with reductions in adolescent firearm suicide attempts and also unintentional firearm deaths in children.

The Present Study - MMWR Content and Methods

23. How was the current study conducted?

Trends in age-adjusted suicide rates were assessed among people aged ≥10 years, by state and sex, and across six consecutive three-year periods (1999-2016), using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among suicide decedents with and without known mental health conditions.

24. What are some of the key findings?

- Across the study period, **suicide rates increased in all states, except Nevada** (which had a consistently high rate throughout).
    - These increases were statistically significant in 44 states.
    - The percentage increases in rates ranged from 5.9% in Delaware to 57.6% in North Dakota, with increases of more than 30% observed in 25 states.
- Suicide rate trends indicated significant increases for males (34 states) and females (43 states), as well as for the U.S. overall.

- While all decedents were predominately male (76.8%) and non-Hispanic white (83.6%), **those without known mental health conditions, relative to those with mental health conditions, were more likely to:**
    - be male (83.6% vs. 68.8%; odds ratio (OR)=2.3, 95% CI = 2.2-2.5)
    - be racial/ethnic minorities (OR range: 1.2-2.0)
    - to die by firearms (OR=1.6, 95% CI= (1.5-1.7).
- Overall, **the large majority of suicides occurred among people ages of 25-64**.
- **More than half of suicide decedents in NVDRS (27 states) did *not* have a known mental health condition.**
    - This group suffered more from relationship problems and other life stressors such as criminal legal matters, eviction/loss of home, and recent or impending crises, however such circumstances were also common in people with mental health conditions.
- **To address the full range of contributing factors to suicide, comprehensive suicide prevention activities are needed.**
    - Such strategies include both upstream prevention to prevent risk from occurring in the first place as well as more downstream activities responsive to the needs of people at increased risk and to prevent re-attempts.
    - The CDC's technical package to prevent suicide provides information about evidence-based strategies, as well as information about the need for a broad, comprehensive approach to preventing suicide.

25. For some states, the reported percentage increase in the suicide rate is quite large. Is this due simply to fluctuations in small numbers of suicides?

The percentages represent increases in rates between the first three-year reporting period (1999-2001) and the last three-year reporting period (2014-2016). By aggregating the data into three-year periods, small suicide counts were avoided. The table below provides the beginning and ending suicide counts and rates for the ten states showing the largest percentage rate increases.

No suicide count appearing in the table below is less than 200, and some counts range into the thousands. Even after recognizing the growth in state populations and any shifts in their age profiles, changes such as those shown would not typically be expected due to random fluctuations alone.

State	Reporting Period	Average Population *	Total Suicides	Annual Rate †	Percentage Increase	Rank
ND	1999-2001	0.56 M	220	13.3	57.6 %	1
	2014-2016	0.65 M	401	20.9		
VT	1999-2001	0.53 M	212	13.2	48.6 %	2
	2014-2016	0.56 M	345	19.7		
NH	1999-2001	1.08 M	435	13.5	48.3 %	3
	2014-2016	1.20 M	719	20.0		
UT	1999-2001	1.84 M	898	17.2	46.5 %	4
	2014-2016	2.48 M	1,809	25.2		

KS	1999-2001	2.31 M	917	13.3	45.0 %	5
	2014-2016	2.51 M	1,446	19.4		
SD	1999-2001	0.65 M	303	15.7	44.5 %	6
	2014-2016	0.74 M	477	22.6		
ID	1999-2001	1.10 M	558	17.3	43.2 %	7
	2014-2016	1.42 M	1,030	24.7		
MN	1999-2001	4.25 M	1,357	10.7	40.6 %	8
	2014-2016	4.77 M	2,161	15.0		
WY	1999-2001	0.43 M	264	20.7	39.0 %	9
	2014-2016	0.51 M	421	28.8		
SC	1999-2001	3.47 M	1,328	12.8	38.3 %	10
	2014-2016	4.29 M	2,310	17.7		

* Average population ≥ 10 years old during reporting period.
† Annual age-adjusted rate per 100,000 population ≥ 10 years old.

26. What is known about which groups are experiencing increases?

The current study found that rates of suicide are increasing, overall, and for males and females. Rates among females increased significantly in 43 states and rates among males increased significantly in 34 states.

- In general, suicide rates in the U.S. have increased by nearly 30% since 1999.
    i. Increases were observed for both women and men in all age groups under 75.
- Certain groups have had particularly high greatest increases since 1999, including:
    i. Working-age adults 35-64 yrs
    ii. Non-Hispanic whites, and non-Hispanic American Indians / Alaska Natives and
    iii. People living in rural areas.
    iv. Rates have increased for males and female however the rate for males is consistently 3-5 times higher than the rate for females

27. How do people with and without mental health conditions differ with respect to suicide?

People with and without mental health conditions had similarities and differences

- While all decedents were predominately male (76.8%) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely male (83.6% vs. 68.8%;) and racial/ethnic minorities (OR range: 1.2-2.0).
- Suicide decedents without known mental health conditions also had significantly greater odds of perpetrating homicide-suicide (adjusted odds ratio aOR = 2.9, 95% CI = 2.2-3.8). Although this represents a small percentage of suicides in both groups.
- While firearms were the most common method of suicide used overall (48.5%) and for both groups, decedents without known mental health conditions were more likely to die by firearm (55.3% vs. 40.6%) and less likely to die by hanging/strangulation/suffocation (26.9% vs 31.3%) or poisoning (10.4% vs 19.8%) than those with known mental health conditions. (These differences remained significant in the adjusted models).

- Among decedents with toxicology results, decedents without known mental health conditions were less likely to test positive for any substance overall (aOR=0.8, 95% CI=0.7-0.8), such as opioids (aOR=.90 95% CI=0.81-.99) but more likely to test positive for alcohol (aOR=1.2, 95% CI=1.1-1.3).
- People without known mental health conditions were less likely to have substance abuse problems (aOR=0.7, 95% CI=0.7-0.8).
- Two-thirds of those with known mental health conditions had a history of mental health or substance abuse treatment (67.2%) and just over half (54.0%) were in current treatment.
- Decedents without, versus those with, known mental health conditions, had significantly greater likelihood of any relationship problem/loss (45.1% vs. 39.6%), specifically intimate partner problems (30.2% vs. 24.1%), arguments/conflicts (17.5% vs. 13.6%), and recently perpetrating interpersonal violence (3.0% vs. 1.4%). They also were more likely to have experienced any life stressors (50.5% vs 47.2%), such as criminal-legal problems (10.7% vs. 6.2%), or eviction/loss of home (4.3% vs. 3.4%) and were more likely to have had a crisis within the preceding or upcoming two weeks (32.9% vs. 26.0%). All of these differences remained significant in the adjusted models.
- Among all people with crises, intimate partner problems were the most common types and did not differ by mental health group status.
- Physical health problems (23.2% and 21.4%) and job/financial problems (15.6% and 16.8%) were commonly experienced by both groups (with and without mental health conditions, respectively)
- Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR=0.5, 95% CI=0.4-0.5), but among those who were recently released (5.1%), they were significantly more likely to be released from a correctional facility (25.7% vs. 8.7%), hospital (43.7% vs. 33.0%), or other facility (e.g., alcohol/substance treatment) (aOR=2.5 95% CI=1.8-3.3), than those with a known mental health conditions. Among decedents with known mental health conditions who were recently released from an institution (10.2%), 46.7% of this group were released from psychiatric facilities.
- Decedents without known mental health conditions, compared to those with mental health conditions, were significantly less likely to have a history of suicidal ideation (23.0% vs. 40.8%) and prior suicide attempts (10.3% vs. 29.4%). More than one in five people in both groups disclosed suicide intent (22.4% vs. 24.5%).

28. Why did Nevada not see an increase in suicide rates?

While Nevada's suicide rate did not increase, it remained consistently high across the study period.

29. Why did this study focus on those aged 10 and older?

Suicide rates were analyzed for people aged ≥10 years only, because determining suicidal intent in younger children can be difficult.

a. Suicide is defined as self-directed injurious behavior with an intent to die as a result of the behavior, and youth under the age of 10 may not fully understand the implications of their actions. (CDC web site)

30. How was "crisis" defined in this study?

For this study, a "crisis" was a current/acute event that occurred within the 2 weeks of a suicide. Crises are indicated in an NVDRS source report to have contributed to the suicide. A crisis can precede the death (e.g., had a bad argument the day before the incident, divorce papers served that day, or victim laid off the week before) or be an impending event (e.g., house was to be foreclosed on the day after

the incident or court date for a criminal offense three days after the suicide). Crises are interpreted from the eyes of the victim. This is particularly relevant for young victims whose crises, such as a bad grade or a dispute with parents over a curfew, may appear to others as relatively minor.

31. How did you define a mental health condition?

The National Violent Death Reporting System (NVDRS) defines a mental health condition as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (9), with the exception of alcohol and other substance use problems, which are captured separately in the system.

a. Data on mental health conditions are abstracted from the investigative reports included within NVDRS and that are associated with each suicide.
b. Investigative reports are those filed by law enforcement and coroners/medical examiners which reflect information provided by family and friends.
c. Information obtained from these reports is dependent upon the extent of informant knowledge that may impact data completeness and accuracy. Some decedents might have mental health conditions that were not diagnosed or reported. The high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

32. Are the people without mental health conditions just people who haven't been diagnosed with a mental health conditions?

It is possible that the people without mental health conditions in this study had a diagnosable mental health condition but had not been diagnosed, or that their mental health conditions was unknown to informants who provided circumstantial information to law enforcement. Studies including more in-depth interviews with next-of-kin often cite greater attributions to mental disorders, however many methodological variations across studies exist. It is likely that some people without known mental health conditions in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

33. Are suicides by people without mental health conditions considered impulsive?

Suicide decedents who do not have mental health conditions should not necessarily be considered impulsive.

- As this study demonstrates, there are many reasons, beyond mental health conditions alone, why people take their own lives.
- 54% of the study sample did not have a known mental health condition, but people in this group still experienced challenges in their lives that contributed to their suicide.
- They may have been experiencing these challenges for an extended period of time and may have had suicidal thoughts leading up to their suicide, which may indicate that the suicide was not impulsive
    - 35% of those without mental health conditions left a suicide note
    - 23% were known to have a history of suicidal ideation
    - 22% had disclosed suicidal intent to another person
    - 10% had previously attempted suicide

34. How many suicides are considered impulsive?

- *A **previous case-control study of survivors of nearly lethal suicide attempts*** indicates that about 24% of this group acted impulsively on their suicidal thoughts
    - i.e., less than 5 minutes passed between their initial thought of suicide and their nearly lethal suicide attempt
    - **76% of attempt survivors did not meet this definition of impulsivity with respect to their suicide attempt.**

35. Is a trigger usually identified, even if that trigger may seem trivial to us? Also, is there data on the effectiveness of resiliency training in preventing suicide?

Triggering events can be difficult to identify. We found that 29% of suicide decedents had experienced a crisis (intimate partner problem, health problem, legal problem), in the past or upcoming two weeks. These crises were seen as contributing to their suicide. That said, it is important to acknowledge that contributing crises can differ across people depending on individual reactions but also family, friend, employer, and community supports.

Programs like the Good Behavior Game (page 32), and Youth Aware of Mental Health program (p32), which are referenced in our technical package and are designed to build coping and problem-solving skills, have shown positive impacts on suicide ideation and/or behavior, however, a key point in our technical package and the conclusion we mean to draw in our MMWR is a comprehensive public health approach to suicide is important. Ideally suicide prevention activities will be incorporated at the individual, relationship, community, and societal levels to have a real impact. The CDC Foundation is currently helping to raise money for us to test this concept in Colorado which consistently has one of the highest rates of suicide in the country. The US Air Force Suicide Prevention Program is the best example of a comprehensive approach that worked (while it was being fully implemented)—they saw reductions in suicide rates of 33% and reductions in related outcomes as well.

36. Why does this study find such a low rate of mental health conditions compared to psych autopsy studies?

Psychological autopsy studies that utilize in-depth interviewing of surviving friends/family and often include record reviews typically show that a larger proportion of suicide decedents have a mental health diagnosis or a substance use disorder. However, variations in the methodology of psychological autopsy studies and the current study may impact the prevalence of mental health conditions identified. It is likely that some people without known mental health conditions in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. NVDRS measures problematic substance use separately from mental health conditions and this report provides an estimate of problematic substance use among those with and without mental health conditions.

The high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

37. Why did you only look at suicide circumstances in 27 states?

a. In 2015, the National Violent Death Reporting System collected data from 27 states. The data collected from these states were used for the analysis. More current data is not yet available.

b. In 2016, NVDRS collected data from 40 states, D.C. and Puerto Rico however data are not yet available.
c. The FY 2018 omnibus appropriation bill provided funding and Congressional direction to expand the NVDRS program to all 50 states and the District of Columbia. CDC is actively working toward that goal.

38. What are some of the limitations to this study?

There are three limitations to the study:

- First, **in the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward), or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward).**
- Second, **NVDRS is not yet nationally representative**; the 27 states included in this study represent 49.6% of the U.S. population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml).
- Third, **abstractors of NVDRS data are limited to information contained in investigative reports.** Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often cite greater attributions to mental disorders, however many methodological variations across studies exist. It is likely that some people without known mental health conditions in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.
- **We know that suicides are underreported.** It is possible that some suicides were coded as unintentional or deaths of undetermined intent. It is unclear how that could impact estimates of trends or conclusions about circumstances.

The National Violent Death Reporting System

39. What is the National Violent Death Reporting System?

- The **National Violent Death Reporting System (NVDRS) is a data system that provides states and communities with a clearer understanding of violent deaths.** NVDRS data can be used to guide local decisions about efforts to prevent violence and track progress over time. NVDRS is the only state-based surveillance (reporting) system that pools data on violent deaths from multiple sources into a usable, anonymous database. These sources include state and local medical examiner, coroner, law enforcement, toxicology, and vital statistics records. Pooling these data can provide CDC with a detailed, comprehensive picture of how and why violent deaths occur.
- **NVDRS includes over 600 unique data elements that provide valuable context about violent deaths such as**
  - Relationship problems; mental health conditions and treatment; toxicology results; and life stressors
    - Including recent problems with a job, finances, or physical health problems.

- Extensive information about the incidents, such as weapons used, characteristics of suspects, and locations where they occurred are included. Such data are far more comprehensive than what is available elsewhere.

- **NVDRS can help identify populations particularly affected by fatal violence**. The system not only provides details on specific manner of violent death, but also identifies common factors that span multiple types of violence.
- The NVDRS FAQ page has more details: https://www.cdc.gov/violenceprevention/nvdrs/faqs.html

40. How does using the National Violent Death Reporting System help to make the statistics more complete?

Although limited to the 27 states participating in NVDRS during the time period of the study, **data from NVDRS provide the only detailed information available on the circumstances surrounding these deaths**, therefore taking the findings beyond reporting numbers and rates and providing unique information on the context in which people die from suicide.

41. Is the National Violent Death Reporting System expanding to 50 states?

We are happy to announce that **beginning in FY18, we are able to make funding available to all 50 states for the implementation of the NVDRS.**

Currently, 40 states, Washington, DC and Puerto Rico are funded by NVDRS.

Expanding NVDRS to 50 states allows us to meet one of the national goals set forth for Healthy People 2020 (IVP-43).

Warning signs of suicide and what to do if you know someone at risk

42. A lot of the problems mentioned as contributing to suicide in this study seem very common, how can someone tell who's at risk?

Many people think that suicide is an inexplicable act, when, in reality, many known risk factors exist.

These include:

- History of previous suicide attempts
- Family history of suicide
- History of child maltreatment
- History of depression or other mental illness
- Alcohol or drug abuse
- Feelings of hopelessness or isolation
- Impulsive or aggressive tendencies
- Stressful life event or loss
- Easy access to lethal methods
- Exposure to the suicidal behavior of others
- Isolation, lack of social connectedness

Researchers agree that suicidal behavior results from an interaction of factors and is rarely due to a single cause.

43. Is suicide genetic?

Research suggests that suicide can run in families. A famous example is the multiple deaths by suicide in the family of American novelist Ernest Hemingway. Both genetics (nature) and environment (nurture) can impact suicide risk; however, there are many strategies to prevent suicide. Suicide is never inevitable.

- A new field of study called epigenetics looks at the interaction of nurture and nature to help us understand risk of suicide.

44. What are the warning signs for suicide?

The warning signs for suicide are:

- Expressing hopelessness
- Increased anger or rage
- Extreme mood swings
- Sleeping too little or too much
- Making plans for suicide
- Talking and/or posting about suicide
- Feeling unbearable pain
- Increased anxiety
- Securing lethal means
- Increased substance use
- Feeling like a burden
- Isolation

45. What should someone do if they believe someone may be suicidal?

- **Ask** the question, "Are you thinking about suicide?" Asking the question won't make someone suicidal, and instead, may relieve or reduce the feeling.
- If the person says yes, **keep** them safe. Find out if they have a suicide plan. Remove any lethal means in the environment, if possible, and do not leave the person alone.
- **Be there** and show concern. Don't act surprised or dismiss their feelings. Take the person seriously, and do not assume they are joking.
- **Help them connect** to resources, for example, by calling the National Suicide Prevention Lifeline (1-800-273-TALK (8255)) or by connecting the person to someone in the community who can help, e.g. emergency department, counselor, pastor.
- **Follow up -** After the person is safe, follow up in the days ahead with a phone call, ask them how they are doing. See if there is anything else that you can do.

You can learn more about these steps to help by going to www.bethe1to.com.

46. Where can people go for help?

No matter what problems people deal with, we want to help them find a reason to keep living. By calling 1-800-273-TALK (8255) people will be connected to a skilled, trained counselor at a crisis center in their area, anytime 24/7. There are many success stories and stories of hope where people in need have reached out to others or family or friends have intervened to get people help. They got the support they needed and were able to get through a crisis and go on to live productive and fulfilling lives.

Suicide among Youth

47. Today's Quick Stat shows rates of suicide and homicide going up among youth. How does this align with rates found in the VS?

The Vital Signs report did not examine suicide rate increases by age group or homicide at all, but we know that suicide is a problem across the lifespan. In fact, suicide rates increase with age up to age 54.

Nationally, we have seen that suicide rates are increasing across all age groups younger than age 75. For example, middle aged adults have the largest number of suicides and have seen particularly high increases in rates. Suicide prevention strategies are needed across the lifespan. States and communities can adopt prevention strategies based on the best available evidence such as those found in the CDC's technical package to prioritize populations with the greatest burden based on both rates and numbers of suicide.

	10-24	25-44	**45-64**	65+
1999 (rate per 100,000)	7.04	13.57	**13.22**	15.80
2016 rate	9.21	16.91	**19.22**	16.66
Percentage increase	31	25	**45**	5
1999 suicide counts	4143	11572	**7977**	5489
2016 suicide counts	6159	14396	**16196**	8204
total counts 1999-2016	86118	221469	**232108**	109915

48. A report came out recently about suicidal thoughts and behavior in youth in Utah. Between these results and other recent findings, should we be focused primarily on youth suicide prevention?

Suicide at any age is troubling and a cause for concern. Today's Vital Signs did not look at suicide rate increases by age group; however, in order to bring rates down, we must apply effective suicide prevention strategies to those population groups at greatest risk and with the greatest burden (based on rates and numbers of suicide).

Note: The Utah study results show similar suicide attempt rates to the National YRBS and while the percentage of people with ideation is greater than the national percentage, in Utah, rates of suicide ideation were defined by any serious thoughts of suicide in the past 12 months or any suicide planning. National rates do not combine these questions, which may explain the difference in state and national prevalence.

	Utah study	National YRBS
Suicide ideation	20%*	17.7%
Suicide attempts	8.2%	8.6%

*The Utah study included students in grades 6, 8,10, and 12 whereas National YRBS is for students in 9-12th grades. Also, the Utah study combined two questions (any serious thoughts of suicide or suicide plans). The National YRBS estimate shown in for thoughts of suicide only.

49. Is the Netflix series, 13 Reasons Why, making youth suicide rates increase?

While we have seen youth suicide rates increase over the past several years, it is difficult to attribute the increases to any one factor. However, we do know that suicide contagion is a real phenomenon, and that when vulnerable youth are exposed to suicidal thoughts or behaviors, their risk for suicide can increase. The media, including the entertainment industry, can help prevent the risk of suicide contagion by safely reporting on suicide and referring to recommendations available at www.reportingonsuicide.org. In response to season one of 13RW and in preparation for Season 2, SAVE (Suicide Awareness Voices of Education) convened a group of experts in suicide prevention, mental and physical health, and education to develop tools to help encourage positive responses to the 13 Reasons Why series.

- The group developed a toolkit providing practical guidance and reliable resources for parents, educators, clinicians, youth and media related to the content of the series (suicide, school violence, sexual assault, bullying, substance abuse, etc.). The toolkit can help encourage conversations, identify those at risk and prevent unexpected tragedies. https://www.13reasonswhytoolkit.org/

50. Recently a study came out about high levels of loneliness among youth. Is that why youth suicide rates are going up?

Loneliness or feeling a lack of connectedness to others is a risk factor for suicide among people of all ages. However, for any given individual, suicide is typically not caused by any one thing. Today's Vital Signs reports on the *multiple* contributing factors to suicide including relationship problems, substance misuse, and health, job/financial, and criminal legal problems. To help communities make use of the best available evidence for suicide prevention, CDC released a suicide prevention technical package. Many of the strategies in the technical package are likely to help people feel connected and less lonely. This is an important part of a comprehensive suicide prevention strategy.

51. Recently a study came out about increasing rates of depression, especially among youth. Is that why suicide rates are going up?

On a population level, increases in depression can impact suicide rates, especially untreated depression, however, for any given individual, suicide is typically not caused by one thing. It is unclear how much these trends in depression are influencing the increases in suicide rates. Today's Vital Signs reports on the multiple contributing factors to suicide including relationship problems, substance misuse, and health, job/financial, and criminal legal problems. A comprehensive approach to suicide prevention must address mental health conditions like depression as well as these other factors.

Suicide among Veterans

52. Do you have any information on suicide among Veterans and Military service members?

While we did not describe Veteran suicides in this study, here are some key epidemiologic findings from other reports published by the Departments of Veterans Affairs and Defense, as well as the CDC .

CDC and its partners are currently doing more research to understand the extent to which the general rise in suicide rates can be attributed to the rise in suicide rates among Veterans.

Veterans:

- **Veterans accounted for 18 percent of adult suicides but constituted only 8.5 percent of the U.S. adult population (ages 18+).**

- An average of **20 Veterans died by suicide each day**; roughly **14 of these are not using VHA services**.
- The overall **burden of Veteran suicide is mostly among Veterans of middle to older adult ages**.
    - An estimated 65% of Veteran suicides occurred among Veterans ages 50 years an older
- **Rates dramatically increased from 12/100,000 in 2005 to 110/100,000 in 2014** among young Veterans aged 18-24 years who were using VHA services and were in Operations Enduring Freedom, Iraqi Freedom, or New dawn
- Suicides among young Veterans aged 18-35 years are highly concentrated in a small proportion of counties.
    - Within 17 NVDRS states, an estimated 33% of suicides among Veterans aged 18-35 years occurred in just 3% of U.S. counties and 69% occurred in 13% of U.S. counties. Many of these high burden counties do not have easy access to VHA facilities.
- Accounting for age and sex, risk for suicide was 21 percent higher among Veterans versus civilians.
- Accounting for age, risk for suicide was 2.4 times higher among female Veterans versus female civilians

Active duty:

- Suicide rates have doubled from 12.5 per 100,000 in 2005 to 30 deaths per 100,000 in 2012. Steady declines in recent years have been observed (although this could be because more service members were recently discharged and therefore their suicides would be reflected in the Veteran population)
- Since 2001-2014, 51% of suicide decedents were Army service members; 18% were Air Force service members; 17% were Navy service members; 14% were Marines
- Key epidemiological findings include:
    - 94% were male
    - 72% were of white race
    - 87% were of non-Hispanic ethnicity
    - 83% were under the age of 35 years
    - 88% were in the enlisted ranks of E1-E9
    - 72% only had a high school graduate level of education (or less)
    - 52% were married
    - 68% of suicides were the result of firearm injuries
    - 54% had a history of deployment

53. Do you think the rate increases in suicide across the U.S. is the result of increases in Veteran suicides?

For this study, we were unable to explore the reasons why we observed these state increases. Therefore, we are unable to determine the extent to which the broad increase in suicide rates across the states is the result of increases in the Veteran suicide rate. This question needs further exploration.

54. Is CDC engaged in preventing suicides among Military service members and Veterans?

CDC has partnered with the Departments of Veterans Affairs and Defense on numerous innovative suicide prevention projects to help address and prevent suicide among active duty service members and Veterans.

- The innovations span across public health service. Such efforts are focused to:
    - Improve surveillance of suicide
    - Increase understanding of the antecedents of suicide and potential factors that might protect against risk of suicide
    - Improve early identification of suicide risk and rapid response to those in need of services, and evaluate key population-level suicide prevention policies and strategies being implemented across states and at military installations.

Opioids and Suicide

55. How are suicide, opioid misuse, and Adverse Childhood Experiences related?

We know that adults who experienced Adverse Childhood Experiences, or ACEs, are at risk for both suicide and substance misuse. Additionally, it is important to note that children whose parents are dealing with substance use disorder or have overdosed are experiencing ACEs, as are children whose parents attempt or die from suicide. So addressing trauma and preventing ACEs can be important to prevention of suicide and opioid misuse as well.

56. Why are opioid overdoses increasing?

Drug overdoses killed 63,632 Americans in 2016. Opioids—prescription and illicit—are the main driver of drug overdose deaths. Nearly two-thirds of these deaths (66%) involved a prescription or illicit opioid. Overdose deaths increased in all categories of drugs examined for men and women, people ages 15 and older, all races and ethnicities, and across all levels of urbanization.

The rise in opioid overdose deaths can be outlined in three distinct waves:

- The first wave began with increased prescribing of opioids in the 1990s , with overdose deaths involving prescription opioids (natural and semi-synthetic opioids and methadone) increasing since at least 1999.
- The second wave began in 2010, with rapid increases in overdose deaths involving heroin.
- The third wave began in 2013, with significant increases in overdose deaths involving synthetic opioids – particularly those involving illicitly-manufactured fentanyl (IMF). The IMF market continues to change, and IMF can be found in combination with heroin, counterfeit pills, and cocaine.
- Recent CDC data (Seth P, Scholl L, Rudd RA, Bacon S. Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants — United States, 2015–2016. MMWR Morb Mortal Wkly Rep. ePub: 29 March 2018.) confirms that increases in drug overdose deaths are being driven by continued sharp increases in deaths involving synthetic opioids other than methadone, such as illicitly manufactured fentanyl (IMF).

57. Does prescribing opioids to patients with chronic health conditions increase suicide risk?

Research has shown that chronic health conditions, including painful conditions such as arthritis, migraines, and fibromyalgia, are associated with increased suicide risk. Further, patients receiving opioid therapy for chronic pain are at elevated risk for mental health conditions and suicide attempts. This may reflect an increased likelihood of prescribing opioids by providers to patients with risk factors for suicide, including mental health conditions, chronic pain, and opioid use disorder. Increased opioid availability can also offer greater access to lethal means for suicide.

58. Can the increase in suicides among certain populations be attributed to opioid use, or to chronic pain?

A recent study showed that chronic health conditions are associated with increased suicide risk, particularly when multiple chronic conditions are present (Ahmedani et al., 2017). Opioids can be prescribed for chronic conditions, and patients receiving opioid therapy are at elevated risk of attempting suicide. However, suicide risk might be able to be reduced by improving pain management consistent with prescribing guidelines. For example, in a study of veterans on long-term opioid therapy, approximately 1-2% of patients attempted suicide within 6 months of receiving a prescription. The VA facility engaged in an effort to increase compliance with prescribing guidelines by making more consistent use of drug screening, providing follow-up within 4 weeks for patients initiating new opioid prescriptions, and avoiding co-prescribing of sedatives with opioids. The study found that by providing follow-up as recommended in the guideline, the risk of suicide could be reduced by 5 times (Im et al., 2015). In a second study, researchers found that compliance with the VA/Department of Defense (DOD)

guideline improved patient safety for VA opioid-prescribed patients (Brennan et al 2016). For example, urine drug screening increased significantly, and this was associated with lower risk of suicide among patients.

59. Has the CDC's Guideline for Prescribing Opioids caused people suffering in pain to contemplate or die by suicide?

Chronic pain can result in considerable suffering. Having a chronic pain condition, compared to no physical pain, is associated with a higher likelihood of suicide, suicidal ideation and suicide attempts, and in many cases this association persists even after controlling for co-morbid mental health and/or substance use disorders. This is the finding of a recent meta-analysis of 30 studies that examined the association of physical pain with a range of suicide related outcomes among people with and without pain conditions. (Ref: Calati, R., Artero, S., Courtet, P., & Lopez-Castroman, J. (2016). Framing the impact of physical pain on suicide attempts. A reply to Stubbs. J Psychiatr Res, 72, 102-103. doi:10.1016/j.jpsychires.2015.10.018)

- **Among patients taking opioids, a recent study suggests that the most important factor that predicts transition from suicidal ideation to suicidal attempt is the belief that pain can't be successfully managed (i.e. hopelessness about pain management), rather than factors such as condition or pain severity.**
- A recent study of US veterans prescribed opioid medications for chronic pain management revealed that a very small percent attempted suicide (less than 2%), and that having a mood disorder increased the risk for suicide attempt. Importantly, use of guideline-recommended practices, including use of urine drug testing, greater-follow-up, and lower co-prescription of sedatives was associated with a lower risk of suicide attempts.

Additional research would tell us more about the associations among chronic pain, opioid use, and suicide, and inform prevention efforts. The available evidence highlights the importance of urine drug testing and avoiding co-prescribing of benzodiazepines, whenever possible, and providers remaining alert to signs of anxiety and depression, using validated instruments to assess for mental health conditions, re-evaluating patients with depression or mental health conditions more frequently than every 3 months, considering use of tricyclic or SNRI antidepressants for analgesic as well as antidepressant effects, and considering behavioral health specialist consultation for any patient with a history of suicide attempt or mental health disorder, as recommended in the CDC Guideline.

60. Why doesn't CDC think chronic pain is important? Why is the prescription drug overdose epidemic the focus?

Chronic pain is a public health concern in the United States. Patients with chronic pain deserve safe and effective pain management.

- Opioids can help manage some types of pain but also have serious risks of addiction and overdose.
- While evidence supports short-term effectiveness of opioids, there is insufficient evidence that opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.

- Primary care providers are concerned about opioid pain medication misuse, are worried about patient addiction, and want more training in prescribing opioids.

CDC's role is to tackle the biggest health problems causing death and disability for Americans, putting science and advanced technology into action to prevent disease and promote healthy and safe behaviors, communities and environment.

CDC recently played a leading role in getting public health goals pertaining to chronic pain included in Healthy People 2020, and facilitated the inclusion of questions about chronic pain in the 2016-17 National Health Interview Survey.

CDC scientific experts also provided review and input regarding the overall National Pain Strategy (NPS) led by HHS. The NPS outlines a coordinated plan for reducing the burden of chronic pain on the American public. It includes key recommendations in areas including population research, prevention and care, disparities, service delivery and payment, professional education and training, and public education and training. The strategy calls for:

- "Developing methods and metrics to monitor and improve the prevention and management of pain.
- Supporting the development of a system of patient-centered integrated pain management practices based on a biopsychosocial model of care that enables providers and patients to access the full spectrum of pain treatment options.
- Taking steps to reduce barriers to pain care and improve the quality of pain care for vulnerable, stigmatized and underserved populations.
- Increasing public awareness of pain, increasing patient knowledge of treatment options and risks, and helping to develop a better informed health care workforce with regard to pain management."

Drug overdose one of the few problems getting worse in US – affecting all ages, races, communities. The opioid overdose crisis is being fueled by both prescription opioids and illicit drugs, like heroin and illicitly-manufactured fentanyl. CDC plays an important role in understanding and addressing the causes of the opioid overdose epidemic.

- Opioids (including prescription opioids, heroin, and fentanyl) killed more than 42,000 people in 2016, more than any year on record.
- 40% of all opioid overdose deaths involve a prescription opioid.
- The best ways to prevent opioid overdose deaths are to improve opioid prescribing, reduce exposure to opioids, prevent misuse, and treat opioid use disorder.

Managing chronic pain is important to the health and well-being of all Americans, and preventing, assessing, and treating chronic pain can be a challenge. Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse opioids, develop opioid use disorder, or overdose from these drugs. The CDC guideline provides recommendations to help determine when to initiate and continue opioid prescribing for pain outside of active cancer treatment, palliative care, and end-of-life care to ensure patients have access to safe and effective chronic pain treatment. CDC aims to save lives and prevent prescription opioid overdoses by equipping providers with the knowledge, tools, and guidance they need.

Adverse Childhood Experiences and Suicide

61. What are ACEs

Adverse Childhood Experiences (ACEs) is the term given to describe types of abuse, neglect, and other household challenges that occur to individuals under the age of 18. The landmark Kaiser ACE Study examined the relationships between these experiences during childhood and reduced health and well-being later in life. The term encompass 10 experiences listed in the original ACE questionnaire.

A. Abuse
   1. Emotional abuse
   2. Physical abuse
   3. Sexual abuse

B. Neglect
   4. Emotional neglect
   5. Physical neglect

C. Household challenges
   6. Substance abuse (of household member)
   7. Mental illness (of household member)
   8. Mother treated violently
   9. Parental separation or divorce
   10. Incarcerated household member

62. What is an ACE score?

The ACE score, a total sum of the different categories of ACEs reported by people, is used to assess cumulative childhood stress. The score ranges from 0 (unexposed) to 10 (exposed to all categories). Study findings repeatedly reveal a graded dose-response relationship between ACEs and negative health and well-being outcomes across the life course.

63. What is CDC doing to prevent ACEs?

Safe, stable, nurturing environments for all children play a large role in preventing ACEs by creating a context and atmosphere that allows families to share quality time together, to discuss and resolve conflicts, and to provide emotional support to one another. CDC's technical package for preventing the different forms of violence impacting children and families can help states and communities prioritize prevention activities based on the best available evidence. These strategies range from a focus on individuals, families, and relationships, to broader community and societal change. For example, the child abuse and neglect technical package includes changing social norms to support parents and positive parenting, enhancing parenting skills to promote health child development, Strengthening economic supports for families, and providing quality care and education early in life, and intervening to lessen harms and prevent future risk.

64. How are ACEs and suicide related?

Research suggests that the greater the number of ACEs, the greater the risk of suicide attempts. ACEs have been associated with increased risk for a variety of outcomes that could contribute to stress and

risk for suicide, including unhealthy coping; physical, mental health, and behavioral health disorders; and diminished life opportunities such as reduced education, employment, and income.

Suicide Prevention

65. Did the study provide recommendations for prevention?

Comprehensive suicide prevention activities both upstream (before suicide risk begins) and downstream (after people have been identified as at-risk, or have attempted suicide) are needed to address the full range of factors contributing to suicide.

- For example, among people with mental health conditions, the study identified a need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to providers in underserved areas is needed, as is expansion of healthcare systems that integrate physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions.
- In addition to strategies addressing mental health conditions, the study identified the need for attention to the broader range of circumstances contributing to suicide, including relationship, substance use, physical health, job, financial, and legal problems.

Taken, together a comprehensive approach to suicide includes the following strategies:

- Identifying and supporting people at risk of suicide.
- Teaching coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments, including safely storing medications and firearms to reduce access among people at risk.
- Connecting people to others in their community so they don't feel alone.
- Connecting people at risk to effective and coordinated mental and physical healthcare.
- Expanding options for temporary assistance for those struggling to make ends meet.
- Preventing future risk of suicide among those who have lost a loved one to suicide

Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices*, available at: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf to better understand their suicide problem, prioritize evidence-based comprehensive suicide prevention, and save lives.

66. What can be done to prevent suicide?

Suicide is preventable.

CDC released a technical package of policies, programs, and practices to prevent suicide to help communities focus on a core set of strategies that have the best available evidence and greatest prevention potential.

The technical package includes examples of programs that local implementers might tailor to fit the needs of their community. The technical package **includes 7 strategies designed to work together to achieve the greatest impact possible**.

i. Strengthen economic supports
ii. Strengthen access and delivery of suicide care
iii. Create protective environments
iv. Promote connectedness
v. Teach coping and problem-solving skills
vi. Identify and support people at risk
vii. Lessen harms and prevent future risk

For example, an evidenced based suicide prevention program called Sources of Strength was developed with rural and tribal communities in North Dakota to promote connectedness between youth and caring adults. The program works to understand and respond to underlying causes of suicidal behavior and promote protective factors against suicidal behavior before the causes result in adverse outcomes.

Other innovative prevention strategies, such as telebehavioral health (telephone, video and web-based technologies), are a promising option to increase access to health care and mental health care in rural communities. However, rural communities often have limited access to the internet suggesting a need to increase broadband access and to identify other ways to deliver promising prevention supports.

Everyone can play a role in suicide prevention.

- Physicians have an important role to play in recognizing and appropriately treating mental health conditions.
- Other professionals who work with vulnerable populations (e.g. parole officers, teachers, etc.) play an important role in identifying and referring at-risk individuals.
- Employers can play a role too.
    - Employee assistance programs can work to reduce stigma about seeking help and improving access to care.

There are also recommendations for the media regarding how to report on suicide to raise awareness without increasing the risk of additional suicides among vulnerable populations. We know that risk can increase when the media provides details about the methods used, dramatic/graphic headlines, or glamorize a death (see reportingonsuicide.org).

67. What is a technical package?

- A technical package is **a collection of strategies that represent the best available evidence to prevent or reduce public health problems like violence**. They can help improve the health and well-being of communities.

CDC's suicide prevention technical package is intended as a resource to guide decision-making in communities and states.

- CDC expert scientists reviewed the literature and summarized the best-available evidence in the technical package. The package has been reviewed by grantees/funded partners, federal partners, and other audiences.
- The technical package highlights seven strategies to prevent suicide.
- This technical package describes programs, practices, and policies along with the evidence of their impact on suicide or risk and protective factors for suicide.
- The strategies are presented in order from those with the greatest potential to produce broad public health impact on suicide followed by those with potential to impact subsets of the population (e.g., persons who have already made a suicide attempt).

68. If suicide rates are increasing, does that mean the evidenced-based strategies that have been identified are not working?

The evidence tells us that there are strategies that work.

- These strategies and approaches do not work if they aren't properly implemented or expanded to reach larger audiences.
- There are many reasons why effective programs are not implemented and expanded, but a lack of funding for suicide prevention has been identified as a contributing factor.

The most effective strategies are comprehensive and use a public health approach as opposed to focusing exclusively on mental health conditions, to impact a broader audience. There is also the issue of stigma around suicide and mental health care, which discourages people at risk for self-harm from seeking help. Suicide is preventable, but we need sufficient investment and a comprehensive public health approach.

69. Where can people go to get more information about suicide prevention?

Visit the CDC Injury Center website at https://www.cdc.gov/violenceprevention/suicide/

70. What partnerships or sectors should be involved in suicide prevention?

- Public health agencies can play an important role in preventing suicide. They can provide leadership and bring critical resources to address the problem. However, the strategies and approaches outlined in CDC's technical package cannot be accomplished by the public health sector alone and require a collective effort across sectors.
- Other sectors vital to prevention efforts include:
    - Education
    - Government (local, state, and federal)
    - Social services
    - Health services
    - Business
    - Labor
    - Justice
    - Housing
    - Media
    - Community organizations (e.g., foundations or faith-based and other organizations)
- Each sector has an important role:
    - Local and state public health agencies and organizations can work to convene partners, lead efforts, track progress, and help evaluate efforts.
    - Education and the public health sector are vital to supporting the development, evaluation, and adoption of effective programs that promote connectedness or that teach coping and problem-solving skills.
    - Business, workplaces, housing, and local and state government entities are in a position to help implement policies and programs that directly address some of the underlying risks and environments that increase the risk for suicide.
    - The healthcare, public health, justice, and social service sectors can work together to identify and support people at-risk of suicide and their families.
    - Across all strategies – community organizations and other non-governmental organizations are vital to prevention.

71. Is it necessary to monitor and evaluate prevention efforts?

- It is important to have data to monitor the extent of the problem so you can see if your prevention efforts are producing the desired impact.
- There are existing data sources for you to consider such as CDC's National Vital Statistics System (NVSS), the National Violent Death Reporting System (NVDRS), the National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP), the Youth Risk Behavior Surveillance System (YRBSS), and the National Survey on Drug Use and Health (NSDUH).
    - If gaps in the data exist, you may want to look for data collected at the local level. YRBSS provides some local data. You may also want to consider data from state and local Child Death Review teams and Suicide Death Review Teams (where available).
- The data you collect can be used to identify and address gaps in surveillance systems as well as plan programs and evaluate the impact of your efforts.

Talking about suicide & suicide contagion

72. Will talking about suicide give people the idea to do it? Could we do more harm than good?

Talking about suicide does not cause suicide to occur.

- In fact, **it can be an excellent prevention tool.**
    - Talking breaks the secrecy that surrounds suicidal behavior and lets people know that help is available.
- **By not talking about suicide, we increase the isolation and despair of individuals thinking about it and perpetuate the stigma associated with suicidal ideation and behavior.**

73. What is meant by "suicide contagion" or "copy-cat" suicide?

These words describe a process by which exposure to suicide or suicidal behavior of one or more persons influences similar behavior by vulnerable individuals. Research has shown that graphic, sensationalized or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion.

74. Do media reports regarding suicide increase the number of copy-cat suicides? What suggestions does CDC have for news media covering suicide issues in their community?

CDC research suggests that stories about suicide can help inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. They can also highlight opportunities to prevent suicide. Media stories about individual deaths by suicide may be newsworthy, but they also have the potential to do harm. Implementation of recommendations for media coverage of suicide has been shown to decrease suicide rates. For more information about these recommendations and tips for covering suicide visit Reporting on Suicide: Recommendations for the Media: https://www.afsp.org/news-events/for-the-media/reporting-on-suicide

75. What suicide story angles should reporters consider?

- Trends in suicide rates accompanied by prevention strategies
- Recent advances in prevention strategies
- Individual stories of how prevention was life-saving

- Stories of people who overcame desperate circumstances without attempting suicide
- Myths about suicide
- Warning signs of suicide
- Actions that individuals or families can take to prevent suicide by others
- Actions that communities can take to support connections among people that help to reduce risk

What role do the economy and social media play in increasing suicide rates?

76. What role does the economy play in increasing suicide rates?

The role of the great recession in the late 2000's and subsequent financial challenges and concerns about economic instability could have contributed to increases in suicide risk. Past research on the association between business cycles and U.S. suicide indicate that the overall suicide rate rises and falls in connection with the economy, with increases during economic recessions. We know that suicides increase in times of economic turmoil, and financial stress experienced by parents may trickle down resulting in vulnerable youth.

77. Is social media use to blame for increasing suicide rates?

More research is needed on the impact of social media use on suicide rates. However, changes in social media content or use patterns could potentially be contributing to risk. Social media can exacerbate bullying, romanticize suicide, and provide harmful content on suicide methods. Alternatively, social media can be used to enhance connections between people, correct myths about suicide, and facilitate access to help. Research is needed to determine how to reduce risk and enhance the protective factors associated with social media.

Select Recent CDC Research

- CDC has released several publications recently.
    - **CDC just released a study on the timing of suicides.**
        - The study examined 122 thousand suicides from the National Violent Death Reporting System in 18 U.S. States from 2003 through 2014.
        - Results: Suicides significantly increased ($p < 0.05$)
            - from March to peak in September before falling, the first week of the month
            - early in the week
            - in the morning, mainly peaking during the afternoon, although suicides in adolescents peaked in the evening and in those 65 years and older peaked in the morning.
            - differences were observed by sex, age, and race/ethnicity.
        - Results from research on suicide timing can potentially help inform planning for prevention activities before periods of relatively high suicide. To help communities make use of the best available evidence for suicide prevention, CDC released a suicide prevention technical package. The technical package describes the importance of a comprehensive approach, which includes Identifying and supporting people at increased suicide risk and upstream approaches that reduce a range of known risk factors.

- Tian, N., Zack, M., Fowler, K. A., & Hesdorffer, D. C. (2018). The Timing of Suicide in 18 United State States from 2003-2014. *Archives of Suicide Research*, (just-accepted), 1-21.

  - In mid-May, **the National Center for Health Statistics released a study describing county-level trends in U.S. suicide rates from 2005-2015.**
    - This study, published in the American Journal of Preventive Medicine, documents that county-level suicide rates increased by more than 10% from 2005 to 2015 in 99% of counties in the U.S.
    - 87% of counties showed an increase of greater than 20%
    - States and communities can use these data in combination with the results from the present study to obtain more granular level detail about suicide rates within their states and to help focus prevention efforts.

  - Late last year, we released **a JAMA article analyzing the number of youth visiting emergency rooms with nonfatal, self-inflicted injuries.**
    - We found that self-inflicted injuries are one of the strongest risk factors for suicide. Our research found that emergency room visits for self-inflicted injuries among young females increased significantly in recent years (2001-2015)-particularly among girls 10-14.
    - And since the risk leads to a potentially fatal outcome, monitoring trends in Self-inflicted injuries is critical to preventing suicide in young people.
      - Mercado MC, Holland K, Leemis RW, Stone DM, Wang J. Trends in Emergency Department Visits for Nonfatal Self-inflicted Injuries Among Youth Aged 10 to 24 Years in the United States, 2001-2015. *JAMA*.2017;318(19):1931–1933. doi:10.1001/jama.2017.13317

  - In February of this year, CDC released **a Morbidity and Mortality Weekly Report (MMWR) summarizing 2014 data from the 18 states participating in the National Violent Death Reporting System (NVDRS) at that time.**
    - Violent deaths due to self-inflicted injury or interpersonal violence disproportionately affected people aged 45-64 men, and American Indian/Alaska Natives.
    - There were several primary precipitating factors for both homicides and suicides that stood out including: intimate partner problems, interpersonal conflicts, mental health and substance abuse conditions, and recent crises
    - NVDRS is currently in 40 states, the District of Columbia, and Puerto Rico, with goals to expand nationally.
    - Developing and expanding NVDRS is crucial to public health efforts at the federal, state, and local levels, in order to identify information like precipitating factors and also to target prevention efforts.
      - Fowler KA, Jack SP, Lyons BH, Betz CJ, Petrosky E. Surveillance for Violent Deaths — National Violent Death Reporting System, 18 States, 2014. MMWR Surveill Summ 2018;67(No. SS-2):1–36.

  - As part of our commitment to suicide prevention in vulnerable populations, in March of this year, CDC released another **MMWR, specifically on suicides among American Indian/Alaska Natives.**
    - It showed that the rates of suicide among American Indian/Alaska Natives have been increasing since 2003.

- Analysis of the data from 18 states, showed that AI/AN people who died by suicide were younger and were more likely to live in a non-metropolitan area than non-Hispanic whites who died by suicide.
- The data show a clear need for culturally relevant intervention strategies for this population.
  Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. MMWR Morb Mortal Wkly Rep 2018;67:237–242.

Partner Activities

1. *What is the National Action Alliance for Suicide Prevention?*
   The National Action Alliance, also referred to as the "Action Alliance" is a public-private partnership that works to advance the National Strategy for Suicide Prevention and make suicide prevention a national priority.

2. *What is the National Strategy for Suicide Prevention?*
   This is a report created by the U.S. Surgeon General and the Action Alliance. It emphasizes the role everyone can play in protecting their friends, family, and colleagues from suicide. It has been revised to include a decade of research and other advancements in order to provide guidance for several sectors like schools, businesses, and health systems.

3. *What is Project 2025?*
   Project 2025 is a collaborative initiative developed by American Foundation of Suicide Prevention (AFSP). The goal of Project 2025 is to reduce the annual suicide rate 20 percent by year 2025. AFSP has determined a series of actions and critical areas to help reach the goal, which includes approaches that reach across all demographic and sociological groups.

4. *What is Zero Suicide?*
   This a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention, and is supported by the Substance Abuse and Mental Health Services Administration It requires that health and behavioral health care systems commit to making suicide prevention a core priority and implement processes and strategies that prevent suicide and improve the care of patients at risk for suicide.

Additional Resources

Recommendations for Media about Safe Reporting on Suicide, reportingonsuicde.org

If you or someone you know is thinking about suicide or needs support, help is always available. Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or visit http://suicidepreventionlifeline.org

Preventing Suicide: A Technical Package of Policy, Programs, and Practices: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf.

National Strategy for Suicide Prevention, http://actionallianceforsuicideprevention.org/national-strategy-suicide-prevention-0

Suicide Prevention Resource Center, https://www.sprc.org/

Centers for Disease Control and Prevention
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Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

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Abstract

Introduction: Suicide rates in the United States have risen nearly 30% since 1999, and mental health conditions are one of several factors contributing to suicide. Examining state-level trends in suicide and the multiple circumstances contributing to it can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among persons aged ≥10 years, by state and sex, across six consecutive 3-year periods (1999–2016), were assessed using data from the National Vital Statistics System for 50 states and the District of Columbia. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health conditions.

Results: During 1999–2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases >30%. Rates increased significantly among males and females in 34 and 43 states, respectively. Fifty-four percent of decedents in 27 states in 2015 did not have a known mental health condition. Among decedents with available information, several circumstances were significantly more likely among those without known mental health conditions than among those with mental health conditions, including relationship problems/loss (45.1% versus 39.6%), life stressors (50.5% versus 47.2%), and recent/impending crises (32.9% versus 26.0%), but these circumstances were common across groups.

Conclusions: Suicide rates increased significantly across most states during 1999–2016. Various circumstances contributed to suicides among persons with and without known mental health conditions.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support persons at risk, prevent reattempts, and help friends and family members in the aftermath of a suicide.

INSIDE

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Continuing Education examination available at https://www.cdc.gov/mmwr/cme/conted_info.html#weekly.

U.S. Department of Health and Human Services
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Introduction

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (*1*). From 1999 to 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (*2,3*). Suicide rates have also increased among persons in all age groups <75 years, with adults aged 45–64 having the largest absolute rate increase (from 13.2 per 100,000 persons [1999] to 19.2 per 100,000 [2016]) and the greatest number of suicides (232,108) during the same period (*1,3*). Suicide is the tenth leading cause of death and is one of just three leading causes that are increasing (*1,4*). In addition, rates of emergency department visits for nonfatal self-harm, a main risk factor for suicide, increased 42% from 2001 to 2016 (*1*). Together, suicides and self-harm injuries cost the nation approximately $70 billion per year in direct medical and work loss costs (*1*).

The National Strategy for Suicide Prevention (*5*) calls for a public health approach to suicide prevention with efforts spanning multiple levels (individual, family/relationship, community, and societal). Such a comprehensive approach underscores that suicide is rarely caused by any single factor, but rather, is determined by multiple factors. Despite this call to action, suicide prevention largely focuses on identifying and referring suicidal persons to mental health treatment and preventing reattempts (*6*). In addition to mental health conditions and prior suicide attempts, other contributing circumstances include social and economic problems, access to lethal means (e.g., substances, firearms) among persons at risk, and poor coping and problem-solving skills (*5*). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them can help reach the national goal, established by the National Action Alliance of Suicide Prevention and the American Foundation for Suicide Prevention, of reducing the annual suicide rate 20% by 2025 (*7*). To assist states in achieving this goal, CDC analyzed state-specific trends in suicide rates and assessed the multiple contributing factors to suicide; this report presents options for strategies to include in comprehensive suicide prevention efforts that are based on the best available evidence.

Methods

Suicide rates were analyzed for persons aged ≥10 years because determining suicidal intent in younger children can be difficult (*8*). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases, Tenth Revision,* underlying-cause-of death codes X60–X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive 3-year aggregate periods spanning 1999–2016 (1999–2001; 2002–2004; 2005–2007; 2008–2010; 2011–2013; and 2014–2016). Rate estimates were age-adjusted to the U.S. 2000 standard population and expressed

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per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same 3-year data aggregates, employing weighted least-squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes.

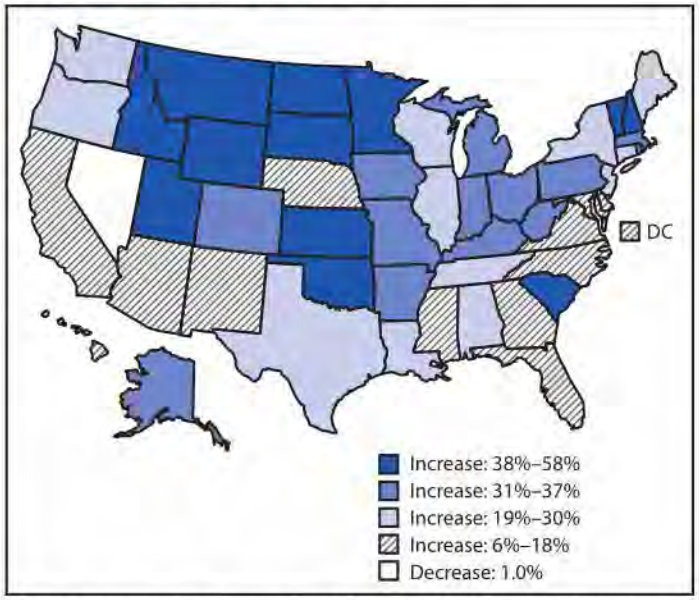
Characteristics of persons aged ≥10 years who died by suicide, with and without known mental health conditions, and the circumstances surrounding the suicides were compared in the 27 states* with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines mental health conditions as disorders and syndromes listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*9*), with the exception of problematic alcohol use and other substance use that are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. A range of circumstances (relationship problems, life stressors, and recent or impending crises) have been identified as potential risk factors for suicide in NVDRS. Circumstances captured are those identified as contributing to suicide in coroner/medical examiner or law enforcement reports, which reflect information provided by family and friends at the time of death. Decedents could have experienced multiple circumstances. Decedents with and without known mental health conditions were compared using chi-square tests. Logistic regression analyses were used to estimate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), controlling for sex, age group, and race/ethnicity.

Results

The most recent overall suicide rates (representing 2014–2016) varied fourfold, from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Across the study period, rates increased in all states except Nevada (where the rate was consistently high throughout the study period), with absolute increases ranging from 0.8 per 100,000 (Delaware) to 8.1 (Wyoming). Percentage increases in rates ranged from 5.9% (Delaware) to 57.6% (North Dakota), with increases >30% observed in 25 states (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785) (Figure).

Modeled suicide rate trends indicated significant increases in 44 states, among males (34 states) and females (43 states), as well as for the United States overall (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785). Nationally, the model-estimated average annual percentage change for the overall suicide rate was an increase of 1.5%. By sex, estimated national rate trends further indicated significant average annual percentage change increases for males (1.1%) and females (2.6%) (Supplementary Table; https://stacks.cdc.gov/view/cdc/53785).

FIGURE. Percent change in annual suicide rate,* by state — United States, from 1999–2001 to 2014–2016



* Per 100,000 population, age-adjusted to the 2000 U.S. standard population.

Suicide decedents without known mental health conditions (11,039; 54.0%) were compared with those with known mental health conditions (9,407; 46.0%) for 27 states. Whereas decedents were predominantly male (76.8%) (Table 1) and non-Hispanic white (83.6%), those without known mental health conditions, relative to those with mental health conditions, were more likely to be male (83.6% versus 68.8%; odds ratio [OR] = 2.3, 95% CI = 2.2–2.5) and belong to a racial/ethnic minority (OR range = 1.2–2.0). Suicide decedents without known mental health conditions also had significantly higher odds of perpetrating homicide followed by suicide (aOR = 2.9, 95% CI = 2.2–3.8). Among decedents aged ≥18 years, 20.1% of those without known mental health conditions and 15.3% of those with mental health conditions had previously served in the U.S. military or were serving at the time of death.

Whereas firearms were the most common method of suicide overall (48.5%), decedents without known mental health conditions were more likely to die by firearm (55.3%) and less likely to die by hanging/strangulation/suffocation (26.9%) or poisoning (10.4%) than were those with known mental health conditions (40.6%, 31.3%, and 19.8%, respectively). These differences remained significant in the adjusted models.

Toxicology testing was less likely to be performed for decedents without known mental health conditions. Among those with toxicology results, decedents without known mental health

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

TABLE 1. Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Sex						
Male	**15,702 (76.8)**	6,469 (68.8)	9,233 (83.6)	<0.01	2.3 (2.2–2.5)	NA
Female	**4,744 (23.2)**	2,938 (31.2)	1,806 (16.4)	<0.01	0.4 (0.4–0.5)	NA
Age group (yrs)**						
10–24	**2,804 (13.7)**	1,211 (12.9)	1,593 (14.4)	<0.01	1.1 (1.1–1.2)	NA
25–44	**6,456 (31.6)**	3,036 (32.3)	3,420 (31.0)	<0.05	0.9 (0.9–1.0)	NA
45–64	**7,718 (37.7)**	3,820 (40.6)	3,898 (35.3)	<0.01	0.8 (0.8–0.8)	NA
≥65	**3,468 (17.0)**	1,340 (14.2)	2,128 (19.3)	<0.01	1.4 (1.3–1.5)	NA
Race/Ethnicity						
White, non-Hispanic	**17,102 (83.6)**	8,165 (86.8)	8,937 (81.0)	<0.01	0.6 (0.6–0.7)	NA
Black, non-Hispanic	**1,228 (6.0)**	411 (4.4)	817 (7.4)	<0.01	1.7 (1.5–2.0)	NA
American Indian/Alaska Native, non-Hispanic	**378 (1.8)**	112 (1.2)	266 (2.4)	<0.01	2.0 (1.6–2.6)	NA
Asian, non-Hispanic	**576 (2.8)**	235 (2.5)	341 (3.1)	<0.05	1.2 (1.1–1.5)	NA
Hispanic	**1,096 (5.4)**	463 (4.9)	633 (5.7)	<0.05	1.2 (1.0–1.3)	NA
Other	**66 (0.3)**	21 (0.2)	45 (0.4)	<0.05	1.8 (1.1–3.1)	NA
Extended demographics						
Ever served in military††	**3,429 (17.8)**	1,354 (15.3)	2,075 (20.1)	<0.01	1.4 (1.3–1.5)	1.1 (1.0–1.1)
Homeless	**240 (1.2)**	104 (1.1)	136 (1.3)	NS	1.1 (0.9–1.5)	1.2 (0.9–1.5)
Incident type						
Single suicide	**20,063 (98.2)**	9,318 (99.1)	10,745 (97.4)	<0.01	0.3 (0.3–0.4)	0.4 (0.3–0.5)
Homicide followed by suicide	**319 (1.6)**	64 (0.7)	255 (2.3)	<0.01	3.5 (2.6–4.5)	2.9 (2.2–3.8)
Multiple suicides	**64 (0.3)**	25 (0.3)	39 (0.4)	NS	1.3 (0.8–2.2)	1.6 (0.9–2.6)
Method						
Firearm	**9,909 (48.5)**	3,821 (40.6)	6,088 (55.3)	<0.01	1.8 (1.7–1.9)	1.6 (1.5–1.7)
Hanging/Strangulation/Suffocation	**5,907 (28.9)**	2,940 (31.3)	2,967 (26.9)	<0.01	0.8 (0.8–0.9)	0.8 (0.7–0.8)
Poisoning	**3,003 (14.7)**	1,861 (19.8)	1,142 (10.4)	<0.01	0.5 (0.4–0.5)	0.6 (0.6–0.7)
Substance class causing death§§						
Other (e.g., over-the-counter)	**1,021 (34.0)**	666 (35.8)	355 (31.1)	<0.01	0.8 (0.7–0.9)	0.9 (0.7–1.0)
Opioids	**944 (31.4)**	608 (32.7)	336 (29.4)	NS	0.9 (0.7–1.0)	0.9 (0.8–1.1)
Antidepressants	**800 (26.6)**	644 (34.6)	156 (13.7)	<0.01	0.3 (0.2–0.4)	0.3 (0.3–0.4)
Benzodiazepines	**624 (20.8)**	468 (25.1)	156 (13.7)	<0.01	0.5 (0.4–0.6)	0.5 (0.4–0.6)
Antipsychotics	**219 (7.3)**	195 (10.5)	24 (2.1)	<0.01	0.2 (0.1–0.3)	0.2 (0.1–0.3)
Other	**1,595 (7.8)**	780 (8.3)	815 (7.4)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)

See table footnotes on next page.

conditions were less likely to test positive for any substance overall (aOR = 0.8, 95% CI = 0.7–0.8), including opioids (aOR = 0.90, 95% CI = 0.81–0.99), but were more likely to test positive for alcohol (aOR = 1.2, 95%, CI = 1.1–1.3).

Information on circumstances surrounding suicide were available for all decedents with mental health conditions (9,407) and approximately 85% of those without known mental health conditions (9,357) in 27 states (Table 2). Persons without known mental health conditions were less likely to have any problematic substance use (aOR = 0.7, 95% CI = 0.7–0.8) than were persons with known mental health conditions. Whereas two thirds of decedents with known mental health conditions had a history of mental health or substance use treatment (67.2%), just over half (54.0%) were in treatment at the time of death.

Decedents without known mental health conditions had a significantly higher likelihood of any relationship problem/loss (45.1%) than did those with known mental health conditions (39.6%), specifically intimate partner problems (30.2% versus 24.1%), arguments/conflicts (17.5% versus 13.6%), and perpetrating interpersonal violence in the past month (3.0% versus 1.4%). Decedents without known mental health conditions were also more likely than were those with known mental health conditions to have experienced any life stressors (50.5% versus 47.2%) such as recent criminal legal problems (10.7% versus 6.2%) or eviction/loss of home (4.3% versus 3.4%) and were more likely to have had a recent or impending (within the preceding or upcoming 2 weeks, respectively) crisis (a current or acute event thought to contribute to the suicide) (32.9% versus 26.0%). All of these differences remained significant in the adjusted models. Physical health problems and job/financial problems were commonly contributing stressors among both persons without mental health conditions (23.2% and 15.6%, respectively) and those with mental health conditions (21.4%

TABLE 1. (*Continued*) Selected demographic and descriptive characteristics of suicides among persons aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total (N = 20,446) No. (%)	Known mental health condition† (n = 9,407) No. (%)	No known mental health condition (n = 11,039) No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Toxicology results						
Any toxicology testing	**13,317 (65.1)**	6,658 (70.8)	6,659 (60.3)	<0.01	0.6 (0.6–0.7)	0.7 (0.6–0.7)
Positive for ≥1 substance¶¶	**9,913 (74.4)**	5,192 (78.0)	4,721 (70.9)	<0.01	0.7 (0.6–0.7)	0.8 (0.7–0.8)
Substance detected* **						
Alcohol						
Tested	**10,950 (53.6)**	5,409 (57.5)	5,541 (50.2)	<0.01	0.7 (0.7–0.8)	0.8 (0.7–0.8)
Positive	**4,442 (40.6)**	2,115 (39.1)	2,327 (42.0)	<0.01	1.1 (1.0–1.2)	1.2 (1.1–1.3)
Opioids						
Tested	**8,554 (41.8)**	4,258 (45.3)	4,296 (38.9)	<0.01	0.8 (0.7–0.8)	0.8 (0.8–0.9)
Positive	**2,279 (26.6)**	1,238 (29.1)	1,041 (24.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Benzodiazepines						
Tested	**8,124 (39.7)**	4,226 (44.9)	3,898 (35.3)	<0.01	0.7 (0.6–0.7)	0.7 (0.7–0.8)
Positive	**2,464 (30.3)**	1,639 (38.8)	825 (21.2)	<0.01	0.4 (0.4–0.5)	0.5 (0.5–0.6)
Cocaine						
Tested	**7,978 (39.0)**	3,866 (41.1)	4,112 (37.2)	<0.01	0.9 (0.8–0.9)	0.9 (0.9–1.0)
Positive	**499 (6.3)**	216 (5.6)	283 (6.9)	<0.05	1.2 (1.0–1.5)	1.2 (1.0–1.5)
Amphetamines						
Tested	**7,615 (37.2)**	3,696 (39.3)	3,919 (35.5)	<0.01	0.9 (0.8–0.9)	0.9 (0.8–0.9)
Positive	**736 (9.7)**	376 (10.2)	360 (9.2)	NS	0.9 (0.8–1.0)	1.0 (0.8–1.1)
Marijuana						
Tested	**6,569 (32.1)**	3,127 (33.2)	3,442 (31.2)	<0.01	0.9 (0.9–1.0)	0.9 (0.9–1.0)
Positive	**1,471 (22.4)**	710 (22.7)	761 (22.1)	NS	1.0 (0.9–1.1)	0.9 (0.8–1.0)
Antidepressants						
Tested	**5,425 (26.5)**	3,103 (33.0)	2,322 (21.0)	<0.01	0.5 (0.5–0.6)	0.6 (0.6–0.7)
Positive	**2,214 (40.8)**	1,735 (55.9)	479 (20.6)	<0.01	0.2 (0.2–0.2)	0.2 (0.2–0.3)

Abbreviations: CI = confidence interval; NA = not adjusted; NS = not significant; OR = odds ratio.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was used as the reference group.

** Decedents were aged ≥10 years, as per standard in the suicide prevention literature.

†† Denominator is decedents aged ≥18 years with reported military service status.

§§ Denominator is decedents who died by poisoning, including overdose.

¶¶ Denominator is decedents with any toxicology testing.

*** Denominator for each positive group is the number tested for the substance in that group.

and 16.8%, respectively). Similarly, among all persons with recent crises, intimate partner problems were the most common types and did not differ by group.

Decedents without known mental health conditions had significantly lower odds of recent release from any institution (aOR = 0.5, 95% CI = 0.4–0.5). Among those recently released, decedents without known mental health conditions were significantly more likely than decedents with mental health conditions to have been released from a correctional facility (25.7% versus 8.7%), hospital (43.7% versus 33.0%), or other facility, such as an alcohol/substance use treatment facility (24.2% versus 11.6%). Among decedents with known mental health conditions who were recently released from an institution, 46.7% were released from psychiatric facilities.

Decedents without known mental health conditions were significantly less likely to have a history of suicidal ideation (23.0%) or prior suicide attempts (10.3%) compared with those with known mental health conditions (40.8% and 29.4%, respectively). Suicide intent was disclosed by 22.4% and 24.5% of persons without and with known mental health conditions, respectively.

Conclusions and Comments

During 1999–2016, suicide rates increased significantly in 44 states, and 25 states experienced increases >30%. Rates increased significantly among males in 34 states, and females in 43 states. Additional research into the specific causes of these trends is needed. Data from the 27 states participating in NVDRS provide important insight into circumstances surrounding suicide and can help states identify prevention priorities.

TABLE 2. Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Suicide with known circumstances	**18,764 (91.8)**	9,407 (100)	9,357 (84.8)	<0.01	N/A	N/A
Mental health						
Any current diagnosed mental health condition**						
Depression/Dysthymia	—††	7,076 (75.2)	N/A	N/A	N/A	N/A
Anxiety disorder	—††	1,579 (16.8)	N/A	N/A	N/A	N/A
Bipolar disorder	—††	1,431 (15.2)	N/A	N/A	N/A	N/A
Schizophrenia	—††	509 (5.4)	N/A	N/A	N/A	N/A
PTSD	—††	424 (4.5)	N/A	N/A	N/A	N/A
ADD/ADHD	—††	226 (2.4)	N/A	N/A	N/A	N/A
Not specified	—††	760 (8.1)	N/A	N/A	N/A	N/A
Current depressed mood§§	**7,038 (37.5)**	3,962 (42.1)	3,076 (32.9)	<0.01	0.7 (0.6–0.7)	0.7 (0.6–0.7)
Problematic substance use						
Any	**5,319 (28.3)**	2,976 (31.6)	2,343 (25.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Alcohol	**3,268 (17.4)**	1,862 (19.8)	1,406 (15.0)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Other	**3,084 (16.4)**	1,768 (18.8)	1,316 (14.1)	<0.01	0.7 (0.7–0.8)	0.7 (0.7–0.8)
Treatment						
Current mental health/substance use treatment	**5,141 (27.4)**	5,077 (54.0)	64 (0.7)	<0.01	0.01 (0.01–0.01)	0.01 (0.01–0.01)
Ever treated for mental health/substance disorder	**6,717 (35.8)**	6,323 (67.2)	394 (4.2)	<0.01	0.02 (0.02–0.02)	0.02 (0.02–0.03)
Relationship problems/loss						
Any relationship problem/loss	**7,948 (42.4)**	3,726 (39.6)	4,222 (45.1)	<0.01	1.3 (1.2–1.3)	1.3 (1.2–1.4)
Intimate partner problem	**5,098 (27.2)**	2,270 (24.1)	2,828 (30.2)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Perpetrator of interpersonal violence in past month	**414 (2.2)**	131 (1.4)	283 (3.0)	<0.01	2.2 (1.8–2.7)	2.0 (1.6–2.4)
Victim of interpersonal violence in past month	**84 (0.4)**	53 (0.6)	31 (0.3)	<0.05	0.6 (0.4–0.9)	0.8 (0.5–1.2)
Family relationship problem	**1,671 (8.9)**	873 (9.3)	798 (8.5)	NS	0.9 (0.8–1.0)	1.0 (0.9–1.1)
Other relationship problem (nonintimate)	**403 (2.1)**	202 (2.1)	201 (2.1)	NS	1.0 (0.8–1.2)	1.1 (0.9–1.3)
Argument or conflict (not specified)	**2,914 (15.5)**	1,278 (13.6)	1,636 (17.5)	<0.01	1.3 (1.2–1.5)	1.4 (1.3–1.5)
Death of a loved one (any)	**1,497 (8.0)**	826 (8.8)	671 (7.2)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–0.9)
Nonsuicide death	**1,181 (6.3)**	647 (6.9)	534 (5.7)	<0.01	0.8 (0.7–0.9)	0.9 (0.8–1.0)
Suicide of family or friend	**379 (2.0)**	217 (2.3)	162 (1.7)	<0.01	0.7 (0.6–0.9)	0.8 (0.7–1.0)
Other life stressors						
Any life stressor	**9,171 (48.9)**	4,442 (47.2)	4,729 (50.5)	<0.01	1.1 (1.1–1.2)	1.1 (1.0–1.2)
Recent criminal legal problem	**1,588 (8.5)**	586 (6.2)	1,002 (10.7)	<0.01	1.8 (1.6–2.0)	1.7 (1.5–1.9)
Other legal problem	**748 (4.0)**	378 (4.0)	370 (4.0)	NS	1.0 (0.8–1.1)	1.0 (0.9–1.2)
Physical health problem	**4,179 (22.3)**	2,012 (21.4)	2,167 (23.2)	<0.01	1.1 (1.0–1.2)	1.0 (1.0–1.1)
Job/Financial problem¶¶	**2,941 (16.2)**	1,530 (16.8)	1,411 (15.6)	<0.05	0.9 (0.8–1.0)	0.9 (0.8–1.0)
Eviction or loss of home	**722 (3.8)**	317 (3.4)	405 (4.3)	<0.01	1.3 (1.1–1.5)	1.4 (1.2–1.6)
School problem***	**162 (19.9)**	70 (17.8)	92 (21.9)	NS	1.3 (0.9–1.8)	1.3 (0.9–1.9)
Recent release from an institution†††	**1,412 (7.6)**	941 (10.2)	471 (5.1)	<0.01	0.5 (0.4–0.5)	0.5 (0.4–0.5)
Jail/Prison/Detention facility	**203 (14.4)**	82 (8.7)	121 (25.7)	<0.01	3.6 (2.7–4.9)	4.5 (3.2–6.4)
Hospital	**517 (36.6)**	311 (33.0)	206 (43.7)	<0.01	1.6 (1.3–2.0)	1.3 (1.0–1.7)
Psychiatric hospital/institution	**469 (33.2)**	439 (46.7)	30 (6.4)	<0.01	0.1 (0.1–0.1)	0.1 (0.1–0.1)
Other (includes alcohol/SU treatment facilities)	**223 (15.8)**	109 (11.6)	114 (24.2)	<0.01	2.4 (1.8–3.3)	2.5 (1.8–3.3)

See table footnotes on next page.

Suicidologists regularly state that suicide is not caused by a single factor (*5*); however, suicide prevention is often oriented toward mental health conditions alone with regard to downstream identification of suicidal persons, treatment of mental health conditions, and prevention of reattempts. This study found that approximately half of suicide decedents in NVDRS did not have a known mental health condition, indicating that additional focus on nonmental health factors further upstream could provide important information for a public health approach (*10*). Those without a known mental health condition suffered more from relationship problems and other life stressors such as criminal/legal matters, eviction/loss of home, and recent or impending crises.

Similarly, persons with mental health conditions also often experienced other circumstances such as relationship problems and job/financial or physical health problems that contributed to their suicide. These findings point to the need to both prevent the circumstances associated with the onset of mental health conditions and support persons with known mental health conditions to decrease their risk for poor outcomes (*11*). Two thirds of suicide decedents with mental health conditions had a history of treatment for mental health or substance use disorders,

TABLE 2. (*Continued*) Circumstances preceding suicide among decedents aged ≥10 years with and without known mental health conditions — National Violent Death Reporting System, 27 states,* 2015

Characteristic	Total No. (%)	Known mental health condition† No. (%)	No known mental health condition No. (%)	Chi-square p-value	OR§ (95% CI)	Adjusted OR¶ (95% CI)
Crisis within past or upcoming 2 weeks§§§	**5,525 (29.4)**	2,444 (26.0)	3,081 (32.9)	<0.01	1.4 (1.3–1.5)	1.4 (1.3–1.5)
Intimate partner problem	**1,968 (35.6)**	854 (34.9)	1,114 (36.2)	NS	1.1 (0.9–1.2)	1.1 (0.9–1.2)
Physical health problem	**739 (13.4)**	315 (12.9)	424 (13.8)	NS	1.1 (0.9–1.3)	1.0 (0.8–1.2)
Criminal legal problem	**621 (11.2)**	203 (8.3)	418 (13.6)	<0.01	1.7 (1.5–2.1)	1.6 (1.3–1.9)
Family relationship problem	**430 (7.8)**	212 (8.7)	218 (7.1)	<0.05	0.8 (0.7–1.0)	0.9 (0.7–1.1)
Job problem	**354 (6.4)**	191 (7.8)	163 (5.3)	<0.01	0.7 (0.5–0.8)	0.7 (0.5–0.8)
Suicide event/history						
Left a note	**6,468 (34.5)**	3,182 (33.8)	3,286 (35.1)	NS	1.1 (1.0–1.1)	1.2 (1.1–1.2)
Disclosed suicide intent	**4,405 (23.5)**	2,306 (24.5)	2,099 (22.4)	<0.01	0.9 (0.8–1.0)	0.9 (0.8–0.9)
History of ideation	**5,990 (31.9)**	3,838 (40.8)	2,152 (23.0)	<0.01	0.4 (0.4–0.5)	0.4 (0.4–0.5)
History of attempts	**3,732 (19.9)**	2,770 (29.4)	962 (10.3)	<0.01	0.3 (0.3–0.3)	0.3 (0.3–0.3)

Abbreviations: ADD/ADHD = attention deficit disorder/attention deficit hyperactivity disorder; CI = confidence interval; N/A = not applicable; NS = not significant; OR = odds ratio; PTSD = posttraumatic stress disorder; SU = substance use.

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as having a current diagnosis of mental health condition in coroner/medical examiner or law enforcement reports.

§ OR reflects the risk among those without known mental health condition relative to those with known mental health condition.

¶ Logistic regression was used to estimate adjusted OR with 95% CIs after controlling for sex, age group, and race/ethnicity. Known mental health condition was the reference group.

** Includes decedents with one or more diagnosed current mental health conditions, which are not mutually exclusive. Therefore, sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health conditions.

†† The specific type of mental health condition was calculated only among those with one or more known diagnosed mental health conditions.

§§ Not a diagnosis.

¶¶ Denominator is decedents aged ≥18 years.

*** Denominator is decedents aged 10–18 years.

††† Denominator of institution subgroup is decedents with recent release from an institution. Recent release from an institution is defined as having occurred within the past month.

§§§ Denominator of crisis subgroup is decedents with any crisis within past or upcoming 2 weeks. Crises depicted here represent the most commonly occurring categories.

with approximately half in treatment when they died. This finding suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities, such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. In addition, increased access to behavioral health providers in underserved areas is needed, as is expansion of health care systems that integrate physical and behavioral health, with a priority on suicide prevention and patient safety, especially through care transitions (*12*).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belonging and access to informational, tangible, emotional, and social support; and identifying and better supporting persons at risk (e.g., military veterans, persons with physical/mental health conditions) (*12*). Other strategies include creating protective environments (e.g., reducing access to lethal means among persons at risk for suicide, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for persons with mental health conditions and other life challenges), strengthening access to and delivery of care, supporting family and friends after a suicide, and encouraging the media to follow safe reporting recommendations (*12*). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (*10*).

The findings in this report are subject to at least three limitations. First, in the state-level analysis, rankings for four states (Maryland, Massachusetts, Rhode Island, and Utah) might have been affected by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward) or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml). Finally, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can affect data completeness and accuracy. Studies that include more in-depth interviews with next-of-kin often identify greater attributions to mental health disorders

Summary

What is already known about this topic?

In 2016, nearly 45,000 persons died by suicide in the United States. Mental health conditions are one of several contributors to suicide.

What is added by this report?

During 1999–2016, suicide rates increased in nearly every state, including >30% increases in 25 states. 2015 data from 27 states indicate 54% of suicide decedents were not known to have mental health conditions. Relationship, substance use, health, and job or financial problems are among the other circumstances contributing to suicide.

What are the implications for public health practice?

A comprehensive approach using proven prevention strategies, such as those in CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, can help reach the national goal of reducing the annual suicide rate 20% by 2025.

(*13*); however, many methodological variations across studies exist (*14*). It is likely that some persons without known mental health conditions in the current study were experiencing mental health challenges that were unknown, undiagnosed, or not reported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (*12*) to better understand suicide in their populations, prioritize evidence-based comprehensive suicide prevention, and save lives.

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Conflict of Interest

No conflicts of interest were reported.

[1]Division of Violence Prevention, National Center for Injury Prevention and Control, CDC; [2]Division of Analysis, Research, and Practice Integration, National Center for Injury Prevention and Control, CDC.

Corresponding author: Deborah M. Stone, dstone3@cdc.gov, 770-488-3942.

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11. World Health Organization. Risks to mental health: an overview of vulnerabilities and risk factors. Geneva, Switzerland: World Health Organization; 2012. http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf
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14. Pouliot L, De Leo D. Critical issues in psychological autopsy studies. Suicide Life Threat Behav 2006;36:491–510.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 15 Mar 2018 18:22:53 +0000
To: Khalil, George M. (CDC/OID/NCHHSTP)
Cc: Merrick, Melissa T. (CDC/ONDIEH/NCIPC);Holbrook, Joseph (CDC/ONDIEH/NCBDDD);Lutfy, Caitlyn (CDC/OPHPR/DEO)
Subject: RE: Mental Health Work Group Announcements
Attachments: MHWG Suicide Technical Package_Final.pdf

Here you go, thanks!

Deb

From: Khalil, George M. (CDC/OID/NCHHSTP)
Sent: Thursday, March 15, 2018 2:01 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Merrick, Melissa T. (CDC/ONDIEH/NCIPC) ; Holbrook, Joseph (CDC/ONDIEH/NCBDDD) ; Lutfy, Caitlyn (CDC/OPHPR/DEO)
Subject: RE: Mental Health Work Group Announcements

Deb,

Great job today! When you have a moment, can you email me the updated PowerPoint?

Thanks!

George

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, March 14, 2018 10:57 AM
To: Khalil, George M. (CDC/OID/NCHHSTP) <uwm4@cdc.gov>
Cc: Merrick, Melissa T. (CDC/ONDIEH/NCIPC) <kcq7@cdc.gov>; Holbrook, Joseph (CDC/ONDIEH/NCBDDD) <vzt4@cdc.gov>; Lutfy, Caitlyn (CDC/OPHPR/DEO) <vxa3@cdc.gov>
Subject: RE: Mental Health Work Group Announcements

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From: Khalil, George M. (CDC/OID/NCHHSTP)
Sent: Wednesday, March 14, 2018 9:41 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Merrick, Melissa T. (CDC/ONDIEH/NCIPC) <kcq7@cdc.gov>; Holbrook, Joseph (CDC/ONDIEH/NCBDDD) <vzt4@cdc.gov>; Lutfy, Caitlyn (CDC/OPHPR/DEO) <vxa3@cdc.gov>
Subject: FW: Mental Health Work Group Announcements

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From: Khalil, George M. (CDC/OID/NCHHSTP)
Sent: Tuesday, March 13, 2018 7:40 AM
To: 'CDCL-MHWORKGROUP@LISTSERV.CDC.GOV' <CDCL-MHWORKGROUP@LISTSERV.CDC.GOV>
Subject: FW: Mental Health Work Group Announcements



REMINDER: MHWG March Meeting this THURSDAY

Our next meeting is scheduled for March 15, 2018 from 9-10 AM. We will have a business meeting followed by a presentation by Dr. Deb Stone from the Division of Violence Prevention on the Suicide Prevention Technical Package. Please find the agenda and meeting invite attached.

Date: **March 15, 2018 at 9:00 AM**

Location: **Chamblee 106 Rm. 5A or via Skype (Link below and attached)**

Abstract:

To improve program practice across the U.S., a group of scientists led by Dr. Stone from the Division of Violence Prevention (DVP) and the Division of Analysis, Research and Practice Integration (DARPI) developed a technical package of policies, programs and practices for the prevention of suicide. Published in 2017, the technical package provides a core set of strategies to achieve and sustain substantial reductions in self-directed violence based upon the best available evidence. Deb will also discuss an upcoming Vital Signs (VS) on suicide and opportunities of how to get involved including dissemination of the VS material through your networks.

Skype Information:

.....

→ Join Skype Meeting

Join by phone

(404) 553-8912 (Atlanta Dial-in Conference Region) English (United States)

(855) 348-8390 (Atlanta Dial-in Conference Region) English (United States)

Conference ID: (b)(6)

.....

Atlanta Regional Commission Request for

Aging Forum Panel Facilitator

The Atlanta Regional Commission is looking for a speaker from CDC to serve as the facilitator of a panel for their upcoming Aging Forum taking place in May, 2018. Please find information from the ARC below and contact Joe Holbrook (vct4@cdc.gov) and Mary Newton (mnewton@atlantaregional.org) ASAP if interested.

Speakers (panel):

- Jocelyn Chen Wise, Project Director at the Fuqua Center for Late-Life Depression, Emory U.
- David Mueller LPC, Transitions Behavioral Health Programs, Emory IOP
- Stacy Hull, Behavioral Health Lead, Alliant Quality
- Allison Bernal, Chief Nutritionist, Georgia Department of Aging Services

Date: Tuesday, May 8 and Wednesday, May 9. The event will take place from 10 am to 2 pm.

Location: TBD

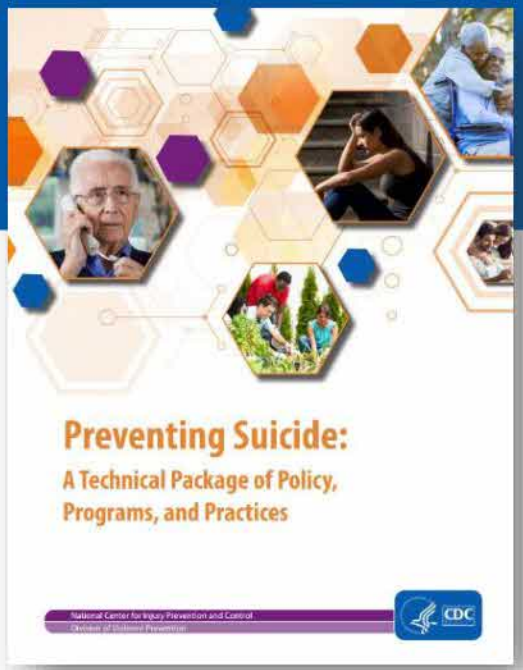
If you have any questions about the Mental Health Work Group, please contact

Melissa Merrick (kcq7@cdc.gov) or Joe Holbrook (vzt4@cdc.gov).

Visit us on the web at http://intranet.cdc.gov/mentalhealth/

You received this message because you are a member of the CDC Mental Health Work Group or because you have signed up for our mailing list.

Suicide Prevention: Technical Package & *New* Vital Signs



CDC Vitalsigns™

Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Deb Stone, ScD, MSW, MPH

Serious Public Health Problem

- Suicide accounts for nearly 45,000 deaths in 2016
- Leading cause of death across the lifespan
- 28% increase since 2000
- High burden in multiple population groups
- Many more people hospitalized or treated in ambulatory settings for nonfatal suicidal behavior than die



Suicide is Preventable



- Connected to other forms of violence
- Shares common risk factors
  - Individual, relationship, community, and societal factors
- Requires a comprehensive approach targeting multiple risk and protective factors across the social ecology
- Primary, secondary, tertiary prevention

Benefits of a Technical Package

Technical packages: one of the six key components for effective public health program implementation

- **Sharpen and focus** what otherwise might be vague commitments to "action"
- **Avoid a scattershot approach** of a large number of interventions, many of which have only a small impact
- Achieve **substantial and synergistic improvement** in outcomes

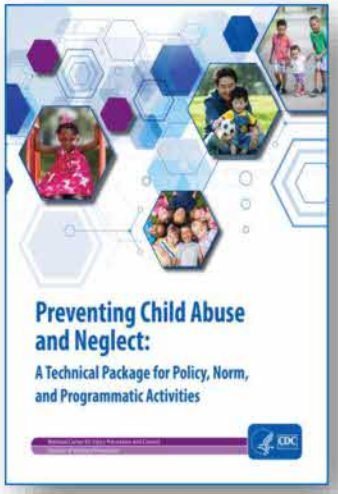


Suicide Technical Package

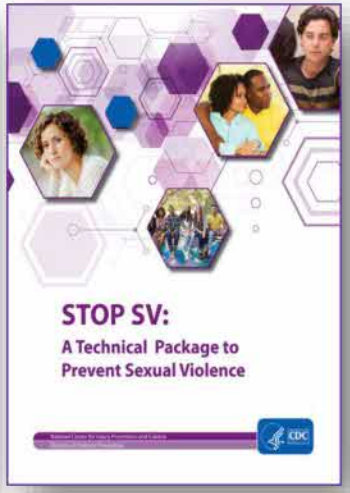


Select group of strategies based on the **best available evidence** *to help communities and states sharpen their focus on priorities with the* **greatest potential** *to prevent suicide.*

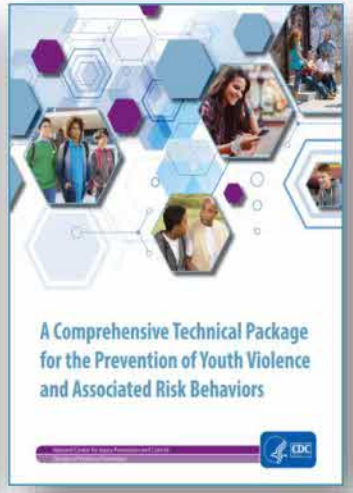
Helping States and Communities Take Advantage of the Best Available Evidence



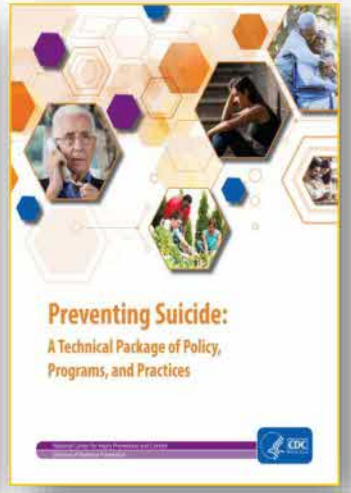
2016



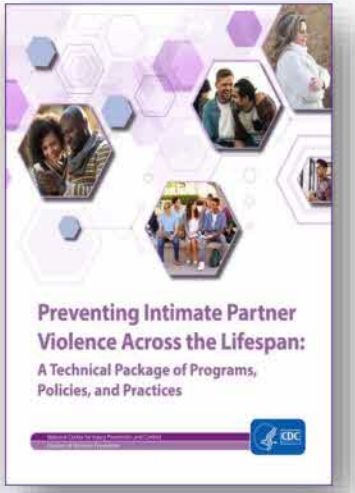
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2017



2017

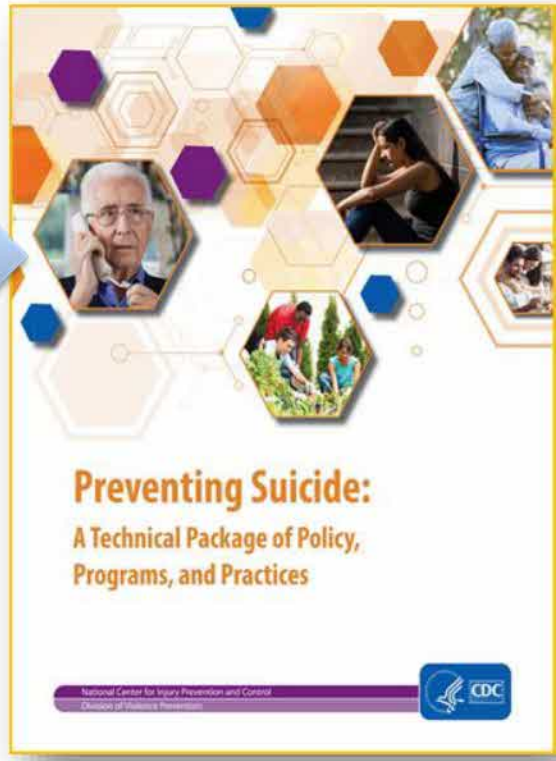
Structure

Three components:

- **Strategy** – direction or action
- **Approaches** – specific ways to advance the strategy (examples: programs; policies; practices)
- **Evidence** – for each approach in preventing violence or impacting risk and protective factors

Technical Package Development





Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., & Wilkins, N. (2017). *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Considerations for Inclusion

- Example programs, policies, and practices selected based on the best available evidence:
  - ✓ Meta-analyses, systematic reviews, rigorous evaluation studies showing impacts on suicide/suicide attempt outcomes or risk/protective factors
  - ✓ Beneficial effects on multiple forms of violence
  - ✓ Similar outcomes with different settings/populations
  - ✓ Feasibility of implementation in U.S. if evaluated in another country
  - ✓ No evidence of harmful effects on specific outcomes or with subgroups

Summary Table

Strategy	Approach
Strengthen economic supports	▪ Strengthen household financial security ▪ Housing stabilization policies
Strengthen access and delivery of suicide care	▪ Coverage of mental health conditions in health insurance policies ▪ Reduce provider shortages in underserved areas ▪ Safer suicide care through systems change
Create protective environments	▪ Reduce access to lethal means among persons at risk of suicide ▪ Organizational policies and culture ▪ Community-based policies to reduce excessive alcohol use
Promote connectedness	▪ Peer norm programs ▪ Community engagement activities
Teach coping and problem-solving skills	▪ Social-emotional learning programs ▪ Parenting skill and family relationship programs
Identify and support people at risk	▪ Gatekeeper training ▪ Crisis intervention ▪ Treatment for people at risk of suicide ▪ Treatment to prevent re-attempts
Lessen harms and prevent future risk	▪ Postvention ▪ Safe reporting and messaging about suicide

Sector Involvement

- Public health
- Education
- Government (local, state, federal)
- Social services
- Business/labor
- Health services
- Justice
- Housing
- Media
- Military and Veteran organizations
- Faith-based and other non-governmental organizations



Monitoring and Evaluation

- Timely and reliable data
  - Monitor extent of problem & evaluate impact of prevention efforts
  - Program planning, implementation and assessment



What's Next?



CDC Vitalsigns™

Goals of the Report

- Report trends in suicide rates in the U.S. and by state and sex.
- Summarize suicide circumstances using the 2015 NVDRS.
- Compare suicide risk factors among people with and without *known* mental health problems
- Highlight that while mental health problems are an important contributor to suicide they are just one of many risk factors implicated.
- Promote suicide prevention as a public health problem requiring a public health solution.
- Promote the CDC Suicide Prevention Technical Package.
- Promote interest in NVDRS among states not involved.

Activities

- Emails from leadership
- GovDelivery
- Telebriefing – CDC Director
- CDC Washington – emails to key congressional offices promoting Vital Signs
- OSTLTS Town Hall
- OSTLTS *Did You Know* – three factoids raising awareness about suicide
- NIH/NIMH webinar – to promote Vital Signs to researchers and MH practitioners
- ASTHO All SHO Call – to promote Vital Signs and technical package to State Health Officers
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Join us in Making a Difference!

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Questions



For more information

Visit CDC's page on the technical packages

https://www.cdc.gov/violenceprevention/pub/technical-packages.html

and other violence prevention pages

www.cdc.gov/violenceprevention



Contact Info
Deb Stone
zaf9@cdc.gov
770-488-3942

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To: Khalil, George M. (CDC/OID/NCHHSTP)
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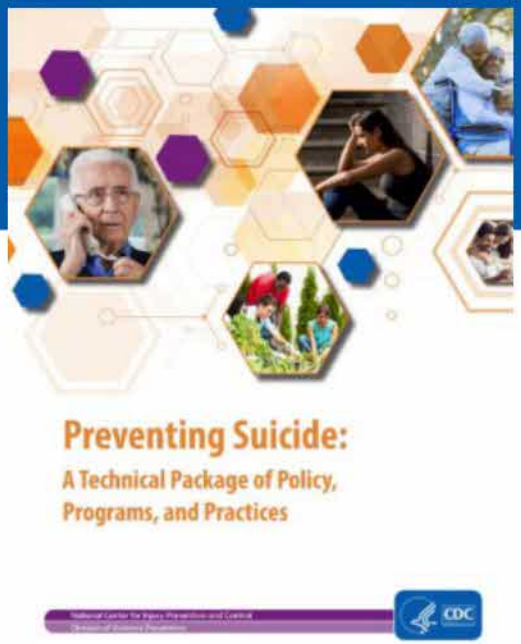
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Suicide Prevention: Technical Package & *New* Vital Signs



CDC Vitalsigns™

Division of Violence PreventionNational Center for Injury Prevention and ControlCenters for Disease Control and Prevention Deb Stone, ScD, MSW, MPH

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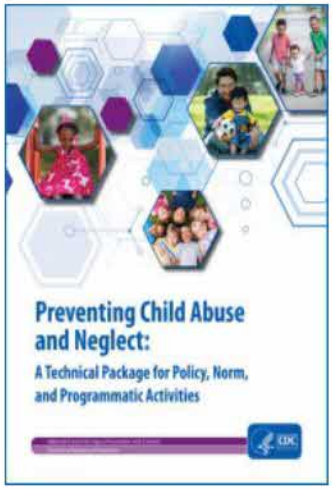


Suicide Technical Package

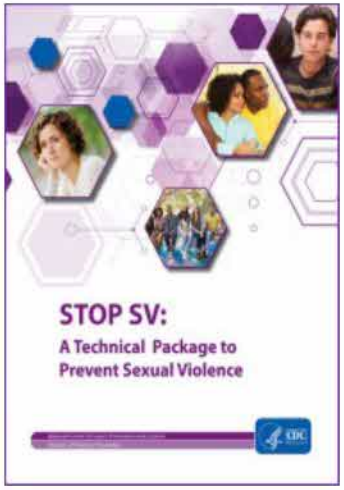


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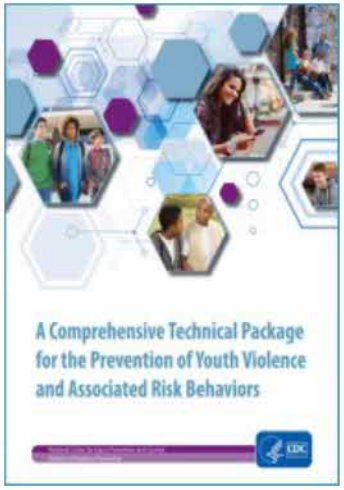
Helping States and Communities Take Advantage of the Best Available Evidence



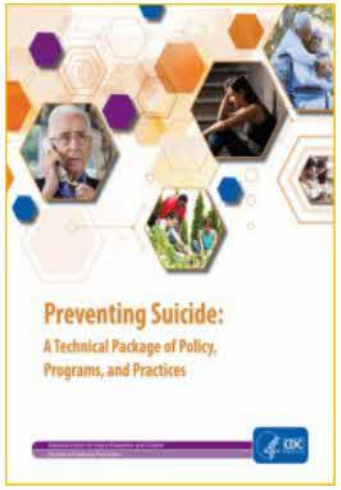
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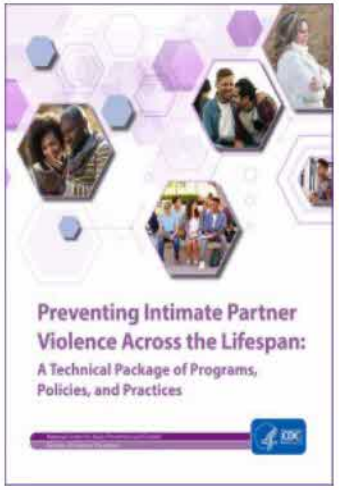
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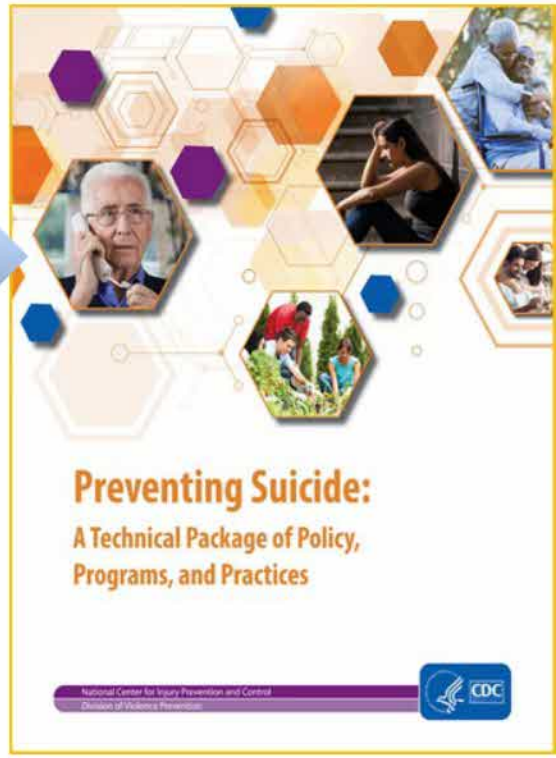
2017

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Lessen harms and prevent future risk	▪ PostventionSafe reporting and messaging about suicide

Sector Involvement

- Public healthEducationGovernment (local, state, federal)Social servicesBusiness/laborHealth servicesJusticeHousingMedia Military and Veteran organizationsFaith-base other non-governmenta organizations



Monitoring and Evaluation

- Timely and reliable dataMonitor extent of problem & evaluate impact of prevention effortsProgram planning, implementation and assessment



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Questions



For more information

Visit CDC's page on the technical packageshttps://www.cdc.gov/violenceprevention/pub/technical-packages.html and other violence prevention pageswww.cdc.gov/violenceprevention



Contact
InfoDeb
Stonezaf9@cdc.gov770-488-3942

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 10 Apr 2018 13:08:36 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: MMWR revision
Attachments: Stone_Suicide Vital Signs MMWR 4.9.18.docx

Hi Deb,
I like the highlighted version of the text below. I suggested a few additional edits in the version attached. Some are just suggestions but a couple are important clarifications. I added comments to explain these. Let me know if you have any questions.
-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, April 9, 2018 6:20 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: MMWR revision

Hi Tom,
I just wanted to send this to you sooner rather than later. This version includes Deb's comments and revisions so far. Waiting to hear back from Keming and Katie where indicated.
I made the revisions you and I discussed:
Despite the NSSP guidance, suicide prevention largely focuses on identifying suicidal people, providing treatment for mental health problems (MHP) and preventing re-attempts (6). In addition to MHP and prior attempts, other contributing circumstances to suicide include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, and poor coping and problem-solving skills (5).
Also wanted to get your thoughts on this option which I think gets a little further at Richard's comments??
Despite the NSSP guidance, suicide prevention has largely focused on identifying and referring suicidal people to mental health treatment and preventing re-attempts (6). In addition to mental health problems (MHP) and prior attempts, other contributing circumstances to suicide include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, and poor coping and problem-solving skills (5).
Deb

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CDC's Injury Center
Preventing Injuries and Violence Through Science and Action

Rev 4.95.18, e-clearance

Short Title: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Deborah M. Stone, ScD;[1] Thomas R. Simon PhD;[1] Katherine A. Fowler, PhD;[1] Scott R. Kegler, PhD;[2] Keming Yuan, MS;[1] Kristin M. Holland, PhD;[1] Asha Z. Ivey-Stephenson, PhD;[1] Alex E. Crosby, MD[1]

Background: The sSuicide rates in the United States hasve risen nearly 30% since 1999. Mental health problems (MHP) are just one factor contributing to suicide. Examining state-level trends in, and the multiple contributing circumstances to, suicide can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among people aged ≥10 years, by state and sex, across six consecutive three-year periods (1999-2016), were assessed using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health problems (MHP).

Results: From 1999-2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases of more than 30%. Rates increased significantly among males and females in 34 and 43 states, respectively. In 2015, more than half (54%) of decedents in 27 states did not have a known MHP. Among people with circumstance information, several circumstances, including relationship problems/loss (45.1% vs 39.6%), life stressors (54.2% vs 49.7%), and recent/impending crises (32.9% vs 26.0%) were significantly more likely among those without a known MHP than decedents with MHP, but were common across groups.

Conclusions: Suicide rates increased significantly across most states from 1999-2016. Various circumstances contributed to suicides among people with and without known MHP.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support people at risk, prevent reattempts, and help friends/family after a suicide occurs.

INTRODUCTION

BACKGROUND AND PURPOSE

In 2016, nearly 45,000 suicides (15.6/100,000 [age-adjusted]) occurred in the United States (U.S.), among people ≥10 years old (1). Between 1999 and 2015, suicide rates increased across sexes, racial/ethnic groups, and urbanization levels (2, 3). Suicide is the 10th leading cause of death and is one of just three leading causes that are *increasing* (1, 4). Additionally, rates of eEmergency dDepartment visits for nonfatal self-harm, a key risk factor for suicide, increased nearly 45% between 2001 and 2015 (1). Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs (1).

The *National Strategy for Suicide Prevention(NSSP)* (5) calls for a public health approach to suicide prevention with efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal). Such an approach underscores that suicide is rarely caused by any single factor, but rather, is multi-determined. Despite the NSSP guidance, suicide prevention ~~efforts are~~ largely ~~clinically-oriented,~~ focusesd on identifying suicidal people, providing ~~treating~~ treatment for mental health problems (MHP) and preventing re-attempts (6). ~~Apart from~~In addition to MHP and prior attempts, other contributing circumstances to suicide include social and economic problems, access to lethal means (e.g., substances, firearms)~~, bridges~~ among people at risk, and poor coping and problem-solving skills (5). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them, can help reach the nation's goal of reducing suicide rates 20% by 2025 (7). To assist states in achieving this goal, this study analyzes state-specific trends in suicide rates, assesses the

Comment [ST(]: Did you pull this from WISQARS yourself? It might be good to have Curtis confirm this. You don't need to do that before sending it up to VS but it would be good to confirm with him before finalizing.

Comment [ST(]: Suggest dropping because very few people die from falls and we don't describe bridges elsewhere.

multiple contributing factors to suicide, and provides ~~recommendations~~ options for multi-level comprehensive suicide prevention based on the best available evidence.

METHODS

Suicide rates were analyzed for people aged ≥10 years only, as determining suicidal intent in younger children can be difficult (8). Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases 10th Revision,* underlying-cause-of death codes X60-X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive three-year aggregate periods spanning 1999-2016. Rate estimates were age-adjusted to the U.S. year 2000 standard population and expressed per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same three-year data aggregates, employing weighted least squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes (AAPCs).

Characteristics and circumstances of suicide decedents ≥10 years old, with and without known MHP, were compared in the 27 states with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015. NVDRS defines MHP as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (9), with the exception of alcohol and other substance dependence, which are captured separately in NVDRS. NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. Decedents with and without known MHP were compared using Chi-square tests. Logistic regression analyses estimated adjusted odds ratios with 95% confidence intervals (CI), controlling for age group, sex, and race/ethnicity.

RESULTS (665)

The most recent overall suicide rates (representing 2014-2016) varied four-fold, from 6.9 (D.C.) to 29.2 (Montana) per 100,000 persons per year (Table 1). Across the study period, rates increased in all states, except Nevada (which had a consistently high rate throughout), with absolute increases ranging from +0.8 (Delaware) to +8.1 (Wyoming) per 100,000. Percentage increases in rates ranged from +5.9% (Delaware) to +57.6% (North Dakota), with increases of more than 30% observed in 25 states (Table 1, Figure 1).

Modeled suicide rate trends indicated significant increases for 44 states, for males (34 states) and females (43 states), as well as for the U.S. overall (Table 1). Nationally, the model-estimated AAPC for the overall suicide rate was +1.5%. By sex, estimated national rate trends further indicated significant increases for males (AAPC +1.1%) and females (AAPC +2.6%).

Suicide decedents without known MHP (N=11,039) were compared to those with MHP (N=9,407) in 27 states. While all decedents were predominately male (Table 2; 76.8%) and non-Hispanic white (83.6%), those without known MHP, relative to those with MHP, were more likely male (83.6% vs. 68.8%; odds ratio (OR)=2.3, 95% CI = 2.2-2.5) and racial/ethnic minorities (OR range: 1.2-2.0). Suicide decedents without known MHP also had significantly greater odds of perpetrating homicide-suicide (adjusted odds ratio aOR = 2.9, 95% CI = 2.2-3.8). Among adult decedents, 20.1% of those without known MHP and 15.3% of those ~~people without and~~ with MHP, ~~respectively,~~ ever served, or were currently serving, in the U.S. military.

While firearms were the most common method of suicide used overall (48.5%) and for both groups, decedents without known MHP were more likely to die by firearm (55.3% vs. 40.6%) and less likely to die by

Comment [ST(]: Suggestion because we don't usually talk about the TP as "recommendations"

Comment [ST(]: Suggested edits for flow.

hanging/strangulation/suffocation (26.9% vs 31.3%) or poisoning (10.4% vs 19.8%) than those with known MHP. These differences remained significant in the adjusted models.

Decedents without known MHP were less likely to receive toxicology testing. Among those with toxicology results, decedents without known MHP were less likely to test positive for any substance overall (aOR=0.8, 95% CI=0.7-0.8) but more likely to test positive for alcohol (aOR=1.2, 95% CI=1.1-1.3).

All suicide decedents with MHP (N=9,407) and approximately 85% without known MHP (N=9,357) had available circumstances information (Table 3). People without known MHP were less likely to have any substance abuse problems (aOR=0.7, 95% CI=0.7-0.8). While two-thirds of those with known MHP had a history of mental health or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment.

Decedents without, versus those with, known MHP, had significantly greater likelihood of any relationship problem/loss (45.1% vs. 39.6%), specifically intimate partner problems (30.2% vs. 24.1%), arguments/conflicts (17.5% vs. 13.6%), and recently perpetrating interpersonal violence (3.0% vs. 1.4%). They also were more likely to have experienced any life stressors (54.2% vs 49.7%), such as criminal-legal problems (10.7% vs. 6.2%), or eviction/loss of home (4.3% vs. 3.4%) and were more likely to have had a crisis within the preceding or upcoming two weeks (32.9% vs. 26.0%). All of these differences remained significant in the adjusted models. Among all people with crises, intimate partner problems were the most common types and did not differ by group. Similarly, among people without versus with MHP, physical health problems (23.2% and 21.4%) and job/financial problems (15.6% and 16.8%) were commonly experienced by both groups~~and did not differ by group~~.

Decedents without known MHP had significantly lower odds of recent release from any institution (aOR=0.5, 95% CI=0.4-0.5), but among those who were recently released (5.1%), they were significantly more likely to be released from a correctional facility (25.7% vs. 8.7%) or hospital (43.7% vs. 33.0%) than those with a known MHP. Among decedents with known MHP who were recently released from an institution (10.2%), 46.7% of this group were released from psychiatric facilities.

Decedents without known MHP, compared to those with MHP, were significantly less likely to have a history of suicidal ideation (23.0% vs. 40.8%) and prior suicide attempts (10.3% vs. 29.4%). More than one in five people in both groups disclosed suicide intent (22.4% vs. 24.5%).

Conclusions and Comments

From 1999-2016, 44 states saw significant increases in suicide rates and 25 states experienced substantial increases in suicide rates of more than 30%. Rates increased significantly among males, in 34 states, and females, in 43 states. This finding is consistent with prior research showing a decreasing gender gap in male-female suicide rates between 1999-2014 (3). Additional research into the specific causes of these trends is necessary. Fortunately, data from the 27 states participating in NVDRS provides important insight into suicide circumstances and can help states identify prevention priorities.

Suicidologists regularly state that suicide is not caused by a single factor; (5) however, suicide prevention ~~research and practice~~ is ~~heavily~~ often oriented towards downstream identification of suicidal people, treatment of MHP and prevention of reattempts. Additional focus on non-mental health factors, further upstream, is essential to a public health approach (10), as the current study found that more than half of suicide decedents in NVDRS did *not* have a known MHP. This group suffered more from relationship problems and other life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises.

Comment [HDE(]: I would add in the % for opioids as it is timely and relevant

Comment [zaf9]: Emailed Keming to ask if the aOR for opioids is significant or not (aOR=.9(.8-1.0)—will insert into the proper place once I know if it's sig or not.

Comment [ST(]: I think this edit is needed because there were differences in the crude comparison and I think one of them remained sig in the aOR. How about just saying they were common in both groups?

Comment [HDE(]: I thought they were also 2x likely to be released from other facility which included drug rehab?

Comment [zaf9]: Emailed Katie about this. Unsure of we want to include this since it could get complicated as 'other' facilities includes alcohol/substance treatment but may also include other facilities.

Similarly, people with MHP often ~~also~~ experienced relationship problems and other life stressors such as job/financial, ~~relationship,~~ and~~/or~~ physical health problems. These findings point to the need to both help people manage ~~prevent~~ the conditions associated with mental health problems in the first place, and to support people with known MHP to decrease their risk of poor outcomes (11). Two-thirds of this group had a history of any mental health and/or substance abuse treatment, with over half in treatment when they died. This suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to behavioral health providers in underserved areas is needed, as is expansion of healthcare systems needed that integrates physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions (12).

Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide. Prevention strategies include: strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills to manage everyday stressors and prevent future relationship problems, especially early in life; promoting social connectedness to increase a sense of belongingness and access to informational, tangible, emotional, and social support; and identifying and better supporting people at risk (e.g., Veterans, people with physical/mental health problems) (12). Other strategies include creating protective environments (e.g., reducing access to lethal means among people at risk, creating organizational and workplace policies to promote help-seeking, easing transitions into and out of work for people with MHP and other life challenges), supporting family and friends after a suicide, and assuring safe reporting by the media in order to prevent suicide contagion (12). Some states, such as Colorado, are planning to implement such a comprehensive approach to suicide prevention (10).

These findings have at least three limitations. In the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent (potentially biasing reported suicide rates downward), or decreased percentages of such deaths over time (potentially biasing estimated rate trends upward). Second, NVDRS is not yet nationally representative; the 27 states included represent 49.6% of the population (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml).

Third, abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can impact data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often see greater attributions to mental disorders (13), however many methodological variations across studies exist (14). It is likely that some people without known MHP in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known MHP~~However, any lack of awareness of decedent MHP~~ suggests the importance of addressing the broad range of factors that contribute to suicide~~contributing circumstances~~.

Suicide is a growing public health problem. Effective approaches to prevent the many suicide risk factors are available. States and communities can use data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices* (12) to better understand their suicide problem, prioritize evidence-based comprehensive suicide prevention, and save lives.

Acknowledgments

Comment [ST(]: I think an edit like this is needed because we aren't going to prevent job or health problems.

Comment [ST(]: What do you think of an edit like this to drive home our main point?

The authors acknowledge Robert Anderson, Holly Hedegaard, and Margaret Warner from the Division of Vital Statistics, National Center for Health Statistics, CDC, for their statistical consultation.

Conflict of Interest No conflicts of interest were reported.

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[1]Division of Violence Prevention, National Center for Injury Prevention and Control, CDC; [2]Division of Analysis, Research, and Practice Integration, National Center for Injury Prevention and Control, CDC

References:

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Attachments:
Stone_Suicide Vital Signs MMWR 3.27.18 (table 1.fig 1)
Stone_Suicide Vital Signs MMWR 4.5.18 (Tables 2&3)
Word Count: 1868/1800

Comment |ST(|: Note typo at the end of the first reference

From: Fowler, Katherine A. (CDC/ONDIEH/NCIPC)
Sent: 25 Apr 2018 14:31:03 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: New VS release date **June 7**

Hi Tom,
You're welcome, and thank you to all of you on the fact sheet team who are making our findings look so great!
Yes, I think "housing stress" sounds fine in that context.
Katie

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 25, 2018 2:29 PM
To: Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: New VS release date **June 7**

Hi Katie,
Thank you for these comments!
Regarding the first one, I think the VS graphics artist will remove the decimals in this figure.
Regarding the second one. I'll change the figure to loss of housing. Are you ok with the more general language in the second sentence: "Among people with or without mental health problems, other issues often contribute to suicide. These include relationship problems or loss, substance use problems, physical health concerns, and job, money, legal, or housing stress."?
Loss of housing is definitely a housing stress.
-Tom

From: Fowler, Katherine A. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, April 24, 2018 1:21 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: New VS release date **June 7**

Hi Tom & Deb-
I think this is looking great – just wanted to share a couple of things, both minor, that popped out at me:

(1) I noticed in the pie charts that we use a decimal for the percentages, which we don't do for the infographic that will show NVDRS circumstances. Not sure if VS prefers one or the other, just noticed that they are different.
(2) In the infographic that will show NVDRS circumstances, I noticed that we list "Housing problems – 4%." Technically, in NVDRS this variable is more narrow than general housing problems. It is specific to eviction/loss of home. It doesn't capture many other types of housing problems, like inability to pay rent, housing instability, and problems with the housing environment, and would therefore probably underestimate the #/% of people having some type of housing problem in general. If there's still time, perhaps we could edit to something like "Loss of housing"?

Thanks,
Katie

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Monday, April 23, 2018 6:23 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD)

<jgx6@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Subject: RE: New VS release date **June 7**

Hi everyone,

We want to share the latest version of the VS fact sheet with you. We received a lot of specific edits last week and the fact sheet subgroup has been working to address them. It is stronger with each iteration. We need to send this back to the VS office by COB on Wednesday so if you have any suggestions or concerns that are important to consider please send them by cob tomorrow.

Thank you!

-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, April 16, 2018 10:10 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Subject: New VS release date **June 7**

Please see Rich's email below. The date of our VS release is now **June 7th** with no early release of the issue.

Thanks,

Deb

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Monday, April 16, 2018 6:35 PM
To: Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>; Dauphin, Leslie (CDC/OD/OADLSS) <lvh7@cdc.gov>
Cc: Sorrells, Marjorie J. (CDC/OD/OCS) <isg8@cdc.gov>; Downie, Diane (Dee Dee) (CDC/CGH/DGHP) <ftl9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Bonds, Michelle E. (CDC/OD/OADC) <meb0@cdc.gov>; Roberts, Ursula (CDC/OD/OCS) (CTR) <nka7@cdc.gov>; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>; Glynn, Kate (CDC/OPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; lademarco, Michael (CDC/OPHSS/CSELS/OD) <mai9@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Smith, Rhonda K. (CDC/OD/OADC) <zby0@cdc.gov>; Smith, Patti (CDC/OD/OADC) <pab0@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>
Subject: Change in June VS release date go Thurs June 7

Folks,

We're now set up have the Tues June 5 Suicide Prevention VS release and telebriefing moved to Thurs June 7 at Noon instead. There will not be an early release of this issue as we usually do. This should better accomodate Dr. Schuchat's travel schedule.

Thank you.

Rich

Rich Schieber, MD MPH
CAPT, USPHS

Director, CDC Vital Signs Program
RBS4@cdc.gov
404 697 9666

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 23 Apr 2018 18:22:47 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Subject: RE: New VS release date **June 7**
Attachments: Suicide VS FS V2_4.9.2018_4pm after VS input to VS group.docx

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We want to share the latest version of the VS fact sheet with you. We received a lot of specific edits last week and the fact sheet subgroup has been working to address them. It is stronger with each iteration. We need to send this back to the VS office by COB on Wednesday so if you have any suggestions or concerns that are important to consider please send them by cob tomorrow.
Thank you!
-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, April 16, 2018 10:10 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Subject: New VS release date **June 7**

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Thanks,
Deb

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Monday, April 16, 2018 6:35 PM
To: Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>; Dauphin, Leslie (CDC/OD/OADLSS) <lvh7@cdc.gov>
Cc: Sorrells, Marjorie J. (CDC/OD/OCS) <isg8@cdc.gov>; Downie, Diane (Dee Dee) (CDC/CGH/DGHP) <ftl9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Bonds, Michelle E. (CDC/OD/OADC) <meb0@cdc.gov>; Roberts, Ursula (CDC/OD/OCS) (CTR) <nka7@cdc.gov>; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>; Glynn, Kate (CDC/OPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Iademarco, Michael (CDC/OPHSS/CSELS/OD) <mai9@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Smith, Rhonda K. (CDC/OD/OADC) <zby0@cdc.gov>; Smith, Patti (CDC/OD/OADC) <pab0@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>
Subject: Change in June VS release date go Thurs June 7

Folks,

We're now set up have the Tues June 5 Suicide Prevention VS release and telebriefing moved to Thurs June 7 at Noon instead. There will not be an early release of this issue as we usually do. This should better accomodate Dr. Schuchat's travel schedule.
Thank you.
Rich
Rich Schieber, MD MPH
CAPT, USPHS
Director, CDC Vital Signs Program
RBS4@cdc.gov
404 697 9666

Suicide rates rising across the US

More than a mental health problem

45,000

Nearly 45,000 lives lost in 2016



30%

Suicide rates increased more than 30% in half of states since 1999

50%

More than half of people who died by suicide did not have a known mental health problem

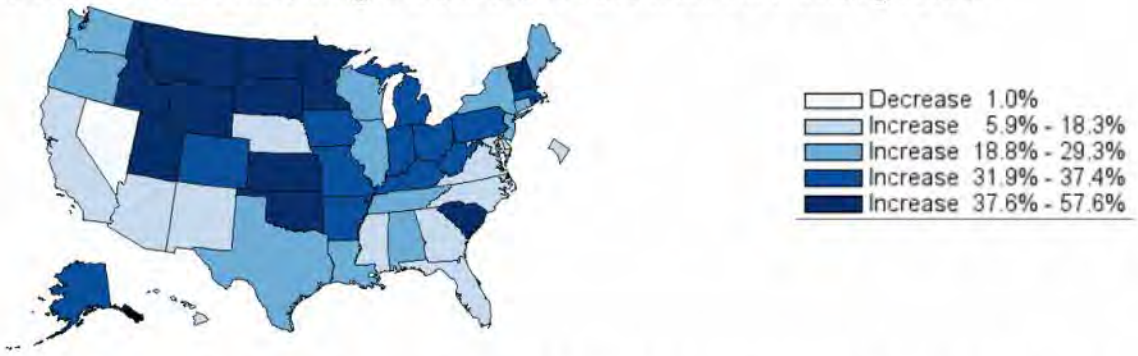
Suicide is a leading cause of death in the US and increased in nearly every state from 1999 through 2016. Although the reasons for the increases need more study, many factors are known to contribute to suicide. Mental health problems are often seen as the cause of suicide, but suicide is rarely caused by any single factor alone. In fact, many people who die by suicide are not known to have a diagnosed mental health problem at the time of death. Among people with or without mental health problems, other issues often contribute to suicide. These include relationship problems or loss, substance use problems, crises, physical health concerns, and job, money, legal, or housing stress. Close coordination of government, public health, healthcare, business, and education sectors, along with media and community-based organizations, is important for preventing suicide. Public health departments can be leaders in bringing together these partners and guiding comprehensive efforts based on the best available evidence.

States and communities can:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Create safe and supportive environments, including securely storing medications and firearms to reduce access among people at risk.
- Connect people to others in their community so they don't feel alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

Problem: State suicide rates are increasing

Suicide rate increases ranged from 6% to 58% from 1999 through 2016



Many people who die by suicide are not known to have a mental health problem.

- Those without known mental health problems are more likely to be male and to die by firearm. Nearly 70% of suicides in both groups are among adults 25-64 years old.



Many factors contribute to suicide among those with or without mental health problems [Note: Icons below will be changed to reflect the problem listed. This is just to convey the idea]



What can states do to prevent suicides?

Use *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* to guide actions based on what is known about keeping people safe **[This could be in a banner going across the page with the link to the technical package www.cdc.gov/violenceprevention/pub/technical-packages.html]**



Learn the suicide warning signs and the steps to keep people safe [Create a new infographic like this one to the left. Use these words but update the image. We would also like to include the "BeThe1To" image.





WHAT CAN BE DONE

The Federal government is:

- Tracking the problem to describe trends, circumstances, and populations at greatest risk (for example see https://www.cdc.gov/violenceprevention/nvdrs/index.html).
- Developing, carrying out, and evaluating suicide prevention strategies
- Working with local, state, tribal, national, and other partners to provide guidance and distribute suicide prevention tools, for example see. www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf

States and communities can:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Create safe and supportive environments, including securely storing medications and firearms to reduce access among people at risk.
- Connect people to others in their community so they don't feel alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

Healthcare systems can:

- Provide high quality, patient-centered, ongoing care focused on patient safety, and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in proven treatment options for patients who are at risk of suicide.

Employers can:

- Promote employee health and well-being, support employees at risk, and have plans in place to respond effectively.
- Encourage employees to seek help. Provide referrals to mental health, substance abuse, legal, or financial counseling services as needed.

Everyone can:

- Reduce access to lethal means, such as medications and firearms, among people at risk.
- Learn the warning signs of suicide and the steps to help identify and connect people at risk to services.
- Contact the National Suicide Prevention Lifeline for help for themselves or others: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org/

[Call out box: The media can follow existing guidelines at www.ReportingOnSuicide.org to help reduce risk (e.g., avoid dramatic headlines) and encourage people to seek help]

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 17 Apr 2018 15:45:37 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC)
Subject: RE: New VS release date **June 7**

Great. Thanks.
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Tuesday, April 17, 2018 11:45 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC)
Subject: RE: New VS release date **June 7**
Yes, I asked Rich about this and he is pursuing for us.

From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Date: April 17, 2018 at 11:40:11 AM EDT
To: Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: New VS release date **June 7**
Thanks, Scott. Tom, have you by chance communicated with NCHS? I don't want to email if you already have.
Deb

From: Kegler, Scott R. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, April 17, 2018 10:47 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: New VS release date **June 7**
I'm sure you've already thought of it, but if not, better get NCHS to move the release date for their data brief, as well.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, April 16, 2018 10:10 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <ivm9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Subject: New VS release date **June 7**
Please see Rich's email below. The date of our VS release is now **June 7th** with no early release of the issue.
Thanks,
Deb

From: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID)
Sent: Monday, April 16, 2018 6:35 PM
To: Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>; Dauphin, Leslie (CDC/OD/OADLSS) <lvh7@cdc.gov>

Cc: Sorrells, Marjorie J. (CDC/OD/OCS) <isg8@cdc.gov>; Downie, Diane (Dee Dee) (CDC/CGH/DGHP) <ftl9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Harben, Kathy (CDC/OD/OADC) <kxh9@cdc.gov>; Bonds, Michelle E. (CDC/OD/OADC) <meb0@cdc.gov>; Roberts, Ursula (CDC/OD/OCS) (CTR) <nka7@cdc.gov>; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>; Glynn, Kate (CDC/OPHSS/CSELS/DSEPD) <mjg6@cdc.gov>; Iademarco, Michael (CDC/OPHSS/CSELS/OD) <mai9@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Smith, Rhonda K. (CDC/OD/OADC) <zby0@cdc.gov>; Smith, Patti (CDC/OD/OADC) <pab0@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>
Subject: Change in June VS release date go Thurs June 7

Folks,

We're now set up have the Tues June 5 Suicide Prevention VS release and telebriefing moved to Thurs June 7 at Noon instead. There will not be an early release of this issue as we usually do. This should better accomodate Dr. Schuchat's travel schedule.

Thank you.

Rich

Rich Schieber, MD MPH
CAPT, USPHS
Director, CDC Vital Signs Program
RBS4@cdc.gov
404 697 9666

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 4 Jun 2018 15:52:07 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC);Frazier, Leroy Jr. (CDC/ONDIEH/NCIPC);Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Cc: Blair, Janet (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: NVDRS Question

Hi Deb,
I suggested an edit in the telebriefing script to include a comment to let the writer know that CDC is collecting data in 40 states, D.C. and Puerto Rico in 2017. These data will start to become available in the fall of 2019.
-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 3:42 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC) ; Frazier, Leroy Jr. (CDC/ONDIEH/NCIPC) ; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Cc: Blair, Janet (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: NVDRS Question

One more question. Will we have data from 40 states in 2018 or 2019?
Deb

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 3:34 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC) <kzm2@cdc.gov>; Frazier, Leroy Jr. (CDC/ONDIEH/NCIPC) <lif6@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Cc: Blair, Janet (CDC/ONDIEH/NCIPC) <zud5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: NVDRS Question

Works for me.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 3:32 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC) <kzm2@cdc.gov>; Frazier, Leroy Jr. (CDC/ONDIEH/NCIPC) <lif6@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Cc: Blair, Janet (CDC/ONDIEH/NCIPC) <zud5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: NVDRS Question

You are welcome. I like the idea of shorter response. Joining this year could be read as starting data collection this year. How about:
CDC expects the remaining states to begin data collection next year. We anticipate releasing estimates in Fall of 2021.
Tom

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 3:22 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; McDavid Harrison, Kathleen

(CDC/ONDIEH/NCIPC) <kzm2@cdc.gov>; Frazier, Leroy Jr. (CDC/ONDIEH/NCIPC) <lif6@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Cc: Blair, Janet (CDC/ONDIEH/NCIPC) <zud5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: NVDRS Question

Thanks for that clarification. I would suggest a shorter response then and just say:
CDC expects the remaining states to join NVDRS this year. We anticipate releasing estimates in Fall of 2021.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 3:08 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC) <kzm2@cdc.gov>; Frazier, Leroy Jr. (CDC/ONDIEH/NCIPC) <lif6@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Cc: Blair, Janet (CDC/ONDIEH/NCIPC) <zud5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: NVDRS Question

Hi everyone,
There are some important nuances to consider here. I just spoke with Shane to confirm.
This part of the response is problematic for a couple of reasons:
Data from all 50 states, DC and Puerto Rico will be available in Summer 2020 (18 months after data collection begins)

- It is possible that not all states will come in for funding and it is likely that not all states will collect state-wide data
- Also they have 16 months from the end of funding to close out the cases so the data won't be available until Fall of 2021.

What if we respond with "CDC expects the remaining states to join NVDRS in Fall of 2018. These states will begin data collection in 2019. We anticipate releasing estimates in Fall of 2021."
-Tom

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 1:47 PM
To: McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC) <kzm2@cdc.gov>; Frazier, Leroy Jr. (CDC/ONDIEH/NCIPC) <lif6@cdc.gov>
Cc: Blair, Janet (CDC/ONDIEH/NCIPC) <zud5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: FW: NVDRS Question

Kathleen and Leroy
Sending this to you as Janet is out of the office.
In prep for the suicide Vital Signs release on Thursday, Dr. Schuchat is asking when we will be able to report on NVDRS for all 50 states. We haven't cleared and answer for this (that I'm aware of but have been working on it). Could you review highlighted text below and see if you agree with this response?

Malia

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 1:43 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Blair, Janet (CDC/ONDIEH/NCIPC) <zud5@cdc.gov>
Subject: RE: NVDRS Question

We have not been asked about this publically yet so we haven't cleared a response. My understanding is the following:
CDC expects the remaining 10 states to join NVDRS by Fall 2018. These states will begin data collection in January 2019.
Data from all 50 states, DC and Puerto Rico will be available in Summer 2020 (18 months after data collection begins)

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 1:29 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Blair, Janet (CDC/ONDIEH/NCIPC) <zud5@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Subject: RE: NVDRS Question

Hi Malia,
Do we have a go to response approved already for this?

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 1:25 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Blair, Janet (CDC/ONDIEH/NCIPC) <zud5@cdc.gov>
Subject: NVDRS Question
Importance: High

Dr. Schuchat's office is asking when we will be able to report on NVDRS for 50 states?
This is for the telebrief.
Thank you.
Deb

Deb Stone, ScD, MSW, MPH
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Suicide, Youth Violence & Elder Maltreatment Team
770.488.3942
dstone3@cdc.gov

CDC's Injury Center
Preventing Injuries and Violence Through Science and Action

From: Brown, Pam (CDC/ONDIEH/NCIPC)
Sent: 1 Jun 2018 14:48:34 -0400
To: Knuth, Alida (CDC/ONDIEH/NCIPC)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Pics from the Suicide Technical Package

Hi Alida,
Images from the Suicide TP that I'd like to provide to CDCF are:

- P.3-pensive man
- P.11-older couple
- P.28-students talking
- P.34-woman listening
- P.44- hands overlapping

Please let me know if you have any questions/concerns.
Thank you very much!!
Pam

From: Knuth, Alida (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 24, 2018 7:39 AM
To: Brown, Pam (CDC/ONDIEH/NCIPC)
Subject: RE: Pics from the Suicide Technical Package

HI Pam,
I was out of the office yesterday. Yes, just send me the page numbers of the images you'd like to provide CDCF. I will be happy to download them for you.
Thanks,
Alida

From: Brown, Pam (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 23, 2018 10:19 AM
To: Knuth, Alida (CDC/ONDIEH/NCIPC) <zlq5@cdc.gov>
Subject: RE: Pics from the Suicide Technical Package

Hi Alida,
Sorry to bug you; just checking back with you about these images.
After looking at the Suicide TP, there are several images that I would like to provide to CDCF, if possible. Would it be helpful for me to list them for you?
Thanks,
Pam

From: Brown, Pam (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 22, 2018 5:27 PM
To: Knuth, Alida (CDC/ONDIEH/NCIPC) <zlq5@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: Pics from the Suicide Technical Package

Hi Alida,
According to my CDCF contact, the Foundation doesn't have a stock photography service and uses pictures from their funded projects.
I'm happy to select specific images from the TP for you to download for this specific use. Are you OK with that?
I'm teleworking tomorrow, and will be out of town [redacted] from May 24-30. Can we talk on the phone tomorrow (5/23) about selecting the images? I'd like to take care of this before I go on leave.

(b)(6)

Thanks,
Pam

From: Knuth, Alida (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 22, 2018 2:25 PM
To: Brown, Pam (CDC/ONDIEH/NCIPC) <jiy3@cdc.gov>
Cc: Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: Pics from the Suicide Technical Package

Hi Pam,
Our licensing agreement for stock photography has some pretty tight limitations on image sharing. Could you check with CDCF to see which stock photography service they are using for images? If they are using the same one, I can just provide the image numbers for the stock photos we used in the TP and they can download them under their license with no worries about rights infringement. If not, maybe you could select specific images you'd like them to use and I can download them again for this specific purpose.
Thanks,
Alida

From: Brown, Pam (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 22, 2018 12:52 PM
To: Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Pics from the Suicide Technical Package

Hi Marie,
Sorry to bother you with this, but I wasn't sure who on your team would be my best contact for this: Can we send files of some of the pictures used in the Suicide Technical Package to the CDCF? The Foundation has created a two-page brief for one of our suicide prevention projects and it looks good except for the stock photos they used. We think some of the pics used in the TP would be a much better suited to our effort (and more consistent with our framing for the work) and I'd like to send a few to CDCF for them to insert into their document. The brief will be used by CDCF (and us) for our outreach to potential funders for the project.
Thanks!
Pam

From: Brown, Pam (CDC/ONDIEH/NCIPC)
Sent: 22 May 2018 17:10:02 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Pics from the Suicide Technical Package

OK, will do; thanks!
Pam

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 22, 2018 5:02 PM
To: Brown, Pam (CDC/ONDIEH/NCIPC)
Subject: RE: Pics from the Suicide Technical Package

Hi Pam,
I'm happy to defer to you. Just don't choose the picture of the older gentleman that's on the front of the technical package. I really dislike that picture!
Deb

From: Brown, Pam (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 22, 2018 3:55 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: Pics from the Suicide Technical Package

Hi Deb,
CDCF doesn't have a stock photography service (per Alida's question).
However, Alida has offered to download specific images from the technical package for us....There are some really nice ones in there. Do you have some favorites?
Pam

From: Knuth, Alida (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 22, 2018 2:25 PM
To: Brown, Pam (CDC/ONDIEH/NCIPC) <jiy3@cdc.gov>
Cc: Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
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Sent: Tuesday, May 22, 2018 12:52 PM
To: Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
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Thanks!
Pam

From: Brown, Pam (CDC/ONDIEH/NCIPC)
Sent: 22 May 2018 15:20:31 -0400
To: Knuth, Alida (CDC/ONDIEH/NCIPC)
Cc: Ballman, Marie R. (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Pics from the Suicide Technical Package

Thanks Alida; this is helpful. I'll check with CDCF and then we'll go from there.
Pam

From: Knuth, Alida (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 22, 2018 2:25 PM
To: Brown, Pam (CDC/ONDIEH/NCIPC)
Cc: Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Pics from the Suicide Technical Package

Hi Pam,
Our licensing agreement for stock photography has some pretty tight limitations on image sharing. Could you check with CDCF to see which stock photography service they are using for images? If they are using the same one, I can just provide the image numbers for the stock photos we used in the TP and they can download them under their license with no worries about rights infringement. If not, maybe you could select specific images you'd like them to use and I can download them again for this specific purpose.
Thanks,
Alida

From: Brown, Pam (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 22, 2018 12:52 PM
To: Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: Pics from the Suicide Technical Package

Hi Marie,
Sorry to bother you with this, but I wasn't sure who on your team would be my best contact for this: Can we send files of some of the pictures used in the Suicide Technical Package to the CDCF? The Foundation has created a two-page brief for one of our suicide prevention projects and it looks good except for the stock photos they used. We think some of the pics used in the TP would be a much better suited to our effort (and more consistent with our framing for the work) and I'd like to send a few to CDCF for them to insert into their document. The brief will be used by CDCF (and us) for our outreach to potential funders for the project.
Thanks!
Pam

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 27 Feb 2018 16:01:29 +0000
To: Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: Please Review Dr. Schuchat's TPs for Appropriate Documentation of Partners
Attachments: 2017-10-31-CNC One Pager.pdf, EXCOM_TPs_v5_jel ds.docx

Ok, here you go. Sorry for the delay. See comments in the document and the revised language.
Are you taking out VS results. See Tom's email. I think he suggested that ?
Partners in CNC: (also included in the attached one pager on the back)
National Partners:

- Centers for Disease Control and Prevention's Injury Control Research Center for Suicide Prevention (ICRC-S)
- Centers for Disease Control and Prevention's National Center for Injury Prevention and Control
- National Action Alliance for Suicide Prevention
- Substance Abuse and Mental Health Services Administration's (SAMHSA) Suicide Prevention Resource Center
- American Foundation for Suicide Prevention

Local Partners:

- Colorado Department of Public Health and Environment (CDPHE)
- Colorado's Suicide Prevention Commission
- Rocky Mountain Mental Illness Research, Education and Clinical Center at the Denver Veterans Administration Medical Centers for Disease Control and Prevention
- Governor's Office
- Colorado Behavioral Healthcare Council
- Colorado School of Public Health
- University of Colorado Depression Center

**Also, if anyone asks re the Vital Signs—Mental Health Problem is defined by NVDRS as currently having a mental health problem (includes those disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) with the exception of alcohol and other substance dependence (as these are captured in separate variables).

From: Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 27, 2018 10:26 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: Please Review Dr. Schuchat's TPs for Appropriate Documentation of Partners

Deb,
Please copy Erin Black when you send your edits.
Thanks,
Valerie

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 27, 2018 9:18 AM
To: Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Subject: RE: Please Review Dr. Schuchat's TPs for Appropriate Documentation of Partners

Sure. I can review at 10.
Deb

From: Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 27, 2018 8:53 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Subject: Please Review Dr. Schuchat's TPs for Appropriate Documentation of Partners

Deb and J.,

Can you take another look at the talking points for Dr. Schuchat? I had Shakiyla Smith in DARPI review the Colorado Collaborative TPs as asked by Tom, but Jim wants to make sure we aren't leaving out any partners that should be acknowledged in this work. J. let me know if you have any edits to the TPs, I drafted these based on the info that Brad shared. I also left in his comments where Dr. Schuchat is providing information that this group knows better than anyone, so we just want to make sure she understands that and can couch it appropriately.

Thanks,

Valerie

Valerie Daniel, MPH, CHES
Acting Health Communication Lead – Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
4770 Buford Highway N.E. MS F-63, Atlanta, GA 30341
770-488-5294 (desk)
guh8@cdc.gov | www.cdc.gov/injury
Telework Tuesdays and Fridays



Preventing Injuries and Violence
Through Science and Action

What is the Colorado-National Collaborative (CNC)?

Goals and Tasks

The goal of the CNC is to create a comprehensive suicide prevention model to reduce suicide statewide by 20% by 2024. Through careful evaluation, the CNC also aims to become a model for other states.

The CNC's tasks include:

- Assessment:
  - Identify counties experiencing the highest numbers and rates of suicide and, in those counties, work to plan prevention efforts. This will involve learning more about the characteristics of people dying by, attempting or contemplating suicide including demographic information (e.g., age, race, marital status), the method used in suicide deaths and attempts, and information about the circumstances surrounding suicide deaths. This information is available through Colorado's Department of Public Health and the Environment, and can be found by clicking here.
  - Work with those counties experiencing the highest numbers and rates of suicide to identify existing prevention initiatives, available resources, existing gaps, and interest in supporting new and enhanced efforts.
  - Inventory existing data and identify gaps in what we know about the problem to help identify the best solutions.
- Capacity Building:
  - Engage partners from diverse systems and settings (e.g., public health, social services, workplaces) that serve individuals and communities at risk, with initial focus on engaging leaders from counties experiencing the highest numbers and rates of suicide.
  - Work with newly-engaged partners to identify how they can contribute to and benefit from the CNC's efforts.
  - Strengthen public awareness and professional education to build suicide prevention capacity.
- Planning:
  - Build on and enhance prevention efforts within health care and community-based settings using a range of evidence-based policies, programs and practices to prevent risk before it occurs and to identify and support people at risk.
  - Facilitate and strengthen coordinated and comprehensive suicide prevention action plans across communities, systems and settings.
- Implementation:
  - Implement coordinated action plans to ensure cost-effective and sustainable change.
- Evaluation:
  - Systematically evaluate progress and outcomes in order to support continual improvement, demonstrate success, and allow Colorado to serve as a model for other states.

Background and History

Colorado's suicide rate, 20.30 per 100,000 in 2016[1], is among the highest in the nation.[2] Solutions to complex public health problems, like suicide, are often most successful when government, businesses, health services, nonprofit organizations, and individual citizens coordinate their efforts. This way, partners can channel their resources to the same goals, avoid duplicating efforts, and enhance each other's work to produce lasting change.

The Colorado-National Collaborative (CNC) is a partnership of scientists and public health professionals working with health and social service agencies, nonprofit organizations, government agencies, businesses, academic organizations, and Colorado residents to identify, promote and implement successful state- and community-based strategies for suicide prevention in Colorado.

Current CNC partners include:

National Partners:

- Centers for Disease Control and Prevention's Injury Control Research Center for Suicide Prevention (ICRC-S)
- Centers for Disease Control and Prevention's National Center for Injury Prevention and Control
- National Action Alliance for Suicide Prevention
- Substance Abuse and Mental Health Services Administration's (SAMHSA) Suicide Prevention Resource Center
- American Foundation for Suicide Prevention

Local Partners:

- Colorado Department of Public Health and Environment (CDPHE)
- Colorado's Suicide Prevention Commission
- Rocky Mountain Mental Illness Research, Education and Clinical Center at the Denver Veterans Administration Medical Center
- Governor's Office
- Colorado Behavioral Healthcare Council
- Colorado School of Public Health
- University of Colorado Depression Center

[1] Vital Statistics Program, Colorado Department of Public Health and Environment
[2] Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WISQARS Online Database

For more information contact Jarrod Hindman, MS, Deputy Chief of Violence and Injury Prevention in the Mental Health Promotion Branch of Colorado's Department of Public Health and the Environment, at jarrod.hindman@state.co.us.

Information on Colorado's Suicide Prevention Efforts and resources can be found by clicking here.



EXCOM Talking Points for Dr. Schuchat

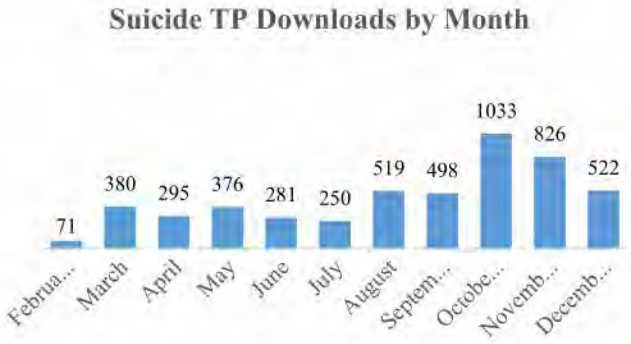
DVP Vital Signs on Suicide (coming out June 5th)

Background on the Problem

- Nearly 45,000 lives are lost every year in the U.S. to suicide.
- More than half of these occur among adults in the prime of their lives, ages 35-64.
- Between 1999 and 2016, suicide rates (age-adjusted) in the U.S. increased by nearly 30% (28.1%), while most other leading causes of death declined.
- Suicide and attempts cost more than $69 billion annually in direct medical and work loss costs.
- Decades of research have shown that suicide is preventable.

Goals of the Vital Signs

- First MMWR report with state specific trends on suicide rates
- Compares suicides in which there was evidence of mental health problems with those without such evidence
- Raise awareness of the increasing suicide rates across states over time
- Increase demand for suicide prevention in states
- Raise awareness that suicide is a public health problem (not just a mental health problem), among both people *with* or *without* mental health problems, multiple factors contribute to suicide
- Highlight the best available evidence for suicide prevention as described in the technical package, *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (released February 27, 2017)



- Downloads February 2017–December 2017: 3050
- Hard copies distributed April 2017-December 2017: 9156
- The spike in October and November is likely due to the promotion following suicide prevention month.
- 86 Websites have cited the technical package. These include local health departments, professional development organizations, advocacy groups, and other federal agencies including the DOJ, DOE, HRSA, and SAMHSA

Background Info on Limited Overlap Between Mental Health/Illness and Suicide

Comment [MJ(]: Of course, this audience knows this very well. I would make sure that Dr. Schuchat understands that and can say something like "As you all well know…"

Comment [MJ(]: Again, this is something this audience knows very well and Dr. Schuchat wants to avoid talking down to them about these things. She should just be alerted so she can couch it appropriately

EXCOM Talking Points for Dr. Schuchat

- Mental health is an important risk factor for suicide, however suicide is typically not caused by any single factor--therefore even if mental illness is present it is likely not the only risk factor/cause
- Many people with mental health problems don't get or delay getting mental health treatment
- Among suicides in people older than 10, more than half ***did not*** have a known mental health problem (2015 NVDRS data).
    - A large proportion had some combination of relationship problems, health problems, job or financial problems, or a recent crisis
- Among those who ***did*** have a known mental health problem
    - About one-third *never* received mental health/substance abuse treatment
    - More than half had any life stressors or crises (some combination of relationship, job, financial, health and other problems)
- Comprehensive prevention as laid out in the technical package is needed.

Colorado Collaborative for a Comprehensive Approach to Suicide Prevention

- The CDC~~,~~ is collaborating with the Colorado Department of Public Health and Environment~~, in collaboration with~~ the CDC-funded Injury Control Research Center (ICRC-S), the Colorado National Collaborative (CNC), and the Colorado Suicide Prevention Commission ~~are collaborating~~ on the first state-wide, large-scale, population-based initiative ~~serving as a model for other states~~ to reduce suicide rates 20% by 2025~~4~~ in CO and to serve as a model for other states to help reduce suicide by 20% by 2025 in the nation.
- The project will pilot test the implementation and evaluation of a comprehensive, integrated approach to suicide prevention – guided, in part, by the CDC/Division of Violence Prevention's (DVP) *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* and from the National Action Alliance for Suicide Prevention's (NAASP) *Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention.*
- Working with CDCF to seek external funding

Why Colorado?

- Colorado consistently ranks among the states with the highest suicide rates in the nation (rate: 19.5 per 100,000 in 2015), almost 50% greater than the U.S. rate of 13.3 per 100,000.
- Colorado has sizable populations at increased risk of suicide, including veterans, American Indian/Alaska Natives (AI/AN), and rural communities.
- Colorado demonstrates readiness as evidenced by a strong state suicide prevention infrastructure, a history of political will, and a proven track record of valuing and implementing public health approaches to prevention. Specifically, the State has:
    - A funded Office of Suicide Prevention (OSP; legislated in 2000)
    - Suicide Prevention Commission (legislated in 2014)
    - Colorado National Collaborative (est. 2015)
    - A strong platform of existing suicide prevention activity
    - A commitment to 'connecting the dots'/shared risk and protective factors

New opportunities for understanding and tracking suicide

Comment [SD(]: Note: CO DPHE and the ICRC-S started the effort so I always try to acknowledge that so it doesn't seem like this was DVP or CDC's idea.

Also, the state goal is a reduction of 20% by 2024 and the national goal is 20% reduction by 2025. Feel free to just keep one or the other. I know it's confusing.

Re Partners. EDC is a collaborator with Univ of Rochester on the ICRC-S but not sure you need to say that as they are also part of the CNC. Other people who are partners on the CNC: Action Alliance, SAMHSA, and AFSP.

Second--Attaching one-pager if this is helpful (you can see all partners on the back).

Comment [MJ(]: Need to change this./ In the room will be many key collaborators not mentioned here, including the Action Alliance itself, the Education Development Center and the American Suicide Foundation. Have you gotten input on this wording from Deb Stone? I would check with her to make sure Dr. Schuchat avoids alienating any important partners.

EXCOM Talking Points for Dr. Schuchat

Linking NVDRS with Departments of Defense and Veterans Affairs data on suicide

- This project will link pertinent data on active duty Military and Veteran suicide decedents across CDC's National Violent Death Reporting System (NDVRS), the Department of Defense Suicide Event Reports, and the Veteran Health Administrative databases.
- Provide more information on suicides among active duty Military personnel and Veterans as well as partition study populations in the NVDRS (e.g., civilians, active duty, VHA Veterans, non-VHA Veterans).
- Help agencies monitor common and unique precipitating factors of suicide captured in NVDRS by group/population and inform comprehensive community-based efforts to help address specific population needs. All linkages will use a de-identified matching technique. No personal identifying information will be used.

Social media intervention

- The purpose of this project is to implement, test, and refine a web-based peer-to-peer therapeutic support platform for U.S. Mmilitary Veterans aimed at preventing suicide and related problems.
- This system called TalkVet, has the potential to bridge the gap between the many social media sites that are widely used by Veterans (e.g., Facebook, Snapchat, etc.) and the growing number of clinical interventions that are available to Veterans, but currently under-utilized.
- With the explicit consent of users, we will test the novel features of the TalkVet platform in three ways:
  1) Use an artificial intelligence (AI) guided system to help identify participating Veterans most in need of help based on their posts and other user activity;
  2) Connect Veterans in need of help with other Veterans participating in TalkVet who can support them; and
  3) Conduct outreach with experimentally refined methods for Veterans in need of a higher level of care to encourage them to obtain such care in the form of links and hand-offs provided by the TalkVet system (this phase of the work will include the use of Veteran moderators with training in crisis counseling who will work with our team).
- This project includes partners from Harvard University, West Virginia University ICRC, TalkLife/Talk/Vet and has been approved by CDC-F.

Comment [MJ(]: Again, don't want to alienate key partners in the room by not first acknowledging them, i.e., the VA especially, they co-chair the Action Alliance. Please check with J Logan about the wording here.

Comment [LJ((]: Partners include Department of Veterans Affairs, Department of Defense Suicide Prevention Office, and the Psychological Health Center of Excellence/Defense Health Agency

Comment [MJ(]: Talkvet is not so much about social media data as it is a social media intervention. Again need to acknowledge partners in this and has anyone talked to J Logan about the wording of this?

Comment [LJ((]: Partner POC if needed:
Drs. Matt Nock and Ron Kessler (Harvard University)
Dr. Rob Bossarte (West Virginia University)

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 3 May 2018 13:20:54 +0000
To: Kingery, Helen H. (CDC/ONDIEH/NCIPC)
Subject: RE: pre-brief

Aww…thank you!!! I super appreciate that!
Deb

From: Kingery, Helen H. (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 3, 2018 7:39 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: pre-brief

You're welcome—I am really rooting for you all! ☺ Your work and topic are so needed in our country at this time. I'm one of DVP's greatest fans!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 2, 2018 7:48 PM
To: Kingery, Helen H. (CDC/ONDIEH/NCIPC) <wzq8@cdc.gov>
Subject: RE: pre-brief

Thank you so much, Helen! This is so helpful. I really appreciate your time and support!!
Deb

From: Kingery, Helen H. (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 1, 2018 10:28 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: pre-brief

Hi Deb! It is not a bother at all, I'm glad to offer what I can! ☺
The pre-brief (is Dr. Schuchat the spokesperson, or is it Dr. Redfield?), is where there are lots of questions, mainly of the SMEs. Dr. Schuchat uses this time to clarify any points in the MMWR and VS materials that either don't make as much sense to her, or that might be missing the mark for media. She basically asks a lot of questions to get her mind wrapped around how to handle all types of questions, to be able to hear your division's voice and priorities, and convey that accurately in her own voice. She also makes excellent recommendations for reframing, if necessary. Take her advice and edits as seriously as possible, and if you cannot, please always develop justification statements! ☺
I would recommend going in person, since you are the primary SME (yes?), along with any other involved SMEs. It's good to get to know Dr. Schuchat and also to interact with the things that she would like to highlight. I would also recommend the main Comm folks (and maybe policy, depending, and definitely Courtney Lenard) go in person to be able to hear all the conversation that goes on in the room (there may be recommended edits and shifts in messaging right on the spot, and it would be helpful to catch/interact with them all while they're happening).
We have typically met in the Director OD suite, so there is a big conference table and some chairs. I think they recommend no more than 7 program folks come in person, but people are welcome to call in. I personally like to reserve a room in Chamblee 106 so that remote program folks can call in together, but that's just my preference, not a requirement at all.
So yeah, this discussion can help you develop/incorporate any final edits/tweaks in messaging to telebriefing script and Q&As, etc. the more you can resolve after this meeting, the smoother the week before the release will be! ☺
Thank you!!
Helen
Helen Kingery, MPH
Health Communication Specialist

CDC | NCIPC | DUIP | OD
Phone: 770.488.0735
Email: HKingery@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 1, 2018 7:39 AM
To: Kingery, Helen H. (CDC/ONDIEH/NCIPC) <wzq8@cdc.gov>
Subject: pre-brief

Hi Helen,

I hate to bother you again but I assume you went to the pre-brief, correct? Can you give me a little bit of lowdown on what happens??! Ours is next Tuesday!

Thanks!

Deb

Deb Stone, ScD, MSW, MPH
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
Suicide, Youth Violence & Elder Maltreatment Team
770.488.3942
dstone3@cdc.gov

CDC's Injury Center
Preventing Injuries and Violence Through Science and Action

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 22 Mar 2018 16:46:40 -0400
To: Black, Erin (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR
Attachments: Suicide Vital Signs MMWR Text 3.19.18 v3 (pre-clearance)_CF_EB MRC.docx

Thanks for the opportunity to review and for all your hard work on this MMWR. It's really exciting to see the final draft! I think this is going to be very important info for states.
I had some minor comments for your consideration that I added to Erin and Cory's feedback (attached). No feedback on the tables and figures. Thought the map of the US that showed the percent change in states was nicely done and easy to understand.
Malia

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 3:25 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Ferdon, Corinne (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR

FABULOUS job Deb! This was very exciting and compelling to read! Congratulations on this huge milestone!
I agree with Jim's comment about emphasizing more the increase in female vs. male rates. I also provided some mostly editorial questions/comments and suggested edits in track changes summarized below:

- Sometimes it is referred to as a 'contributing circumstance' and sometimes its referred to as a 'contributing factor'. I wonder if its best to be consistent so as not to confuse the reader that the two are different. From a plain language perspective, I prefer contributing factors? Also, sometimes it is referred to a just 'contributing factor' while other times it is referred to as 'contributing risk factor'. Also, sometime it is referred to as 'contributing' and sometimes as 'associated'. Should we be consistent?
- "Suicide is the 10th leading cause of death and is among the only leading causes to be *increasing*." Can we be more specific – is it the only or is it only one of 2 (e.g.) leading causes increasing – 'among the only' is vague?
- Is it better to say the current 'social ecology' (which I think many think of social, environmental and economic) versus I think what is used most often the 'social ecological model' (individual, family/relationship, community, and societal).
- "can help reach the nation's goal of reducing suicide rates 20% by 2025" – is it really the 'nation's goal' – versus the goal set by the American Foundation for Suicide Prevention.
- "Across the entire study period, rates increased in all but one state (Nevada)." Per our discussion in our last VS group meeting, should we add a note that despite NV not increasing, they still have a significantly high rate of suicide?
- Sometimes criminal-legal is hyphenated and sometimes it's not.
- "Nearly half of suicide decedents in NVDRS had a known MHP." I would add the actual percentage in parenthesis (X%).
- People with known MHP also experienced other life stressors such as job and/or financial, relationship, and/or physical health problems. Should this be 'and', 'or' or 'and/or'?

- "It is likely that some people without known MHP in the current study were experiencing mental health challenges at the time of death that were either not known or reported by informants." Do you mean 'NOT' reported by informants?

From: Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 2:25 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR

Deb,

Congratulations to you and the entire vital signs writing team to getting to this point! It is an enormous achievement. I really like the direction the analyses have gone in. I know there is a considerable amount of work ahead, but you have a solid platform to build on.

I offer in the attachments some suggestions. Track changes are not easily done in the excel file so I highlight words in red to draw your attention to things to consider. In the text, I think there are a few numbers to double check, a few data points and clarifications to be added in, and the references to the tables/figure adjusted. I do like the balance that is currently in there on the %'s versus aORs.

Mental health problems as a driver of suicide jumped out to me as one of the main messages since the text kept coming back to it. I think there are some subtle reorganization or broader phrasing that could be used in some places to modify this if the communication goal is different; I offer some ideas in comment boxes. I recognize that I am suggesting adding some clarifying text in some places and word count is always an issue, so I did try to identify some places to potentially cut. Please review this as suggestions and take/leave what feels right.

FYI, in a meeting I was in with the MMWR editors yesterday they said they prefer little to no use of acronyms. So, in a few places I suggest taking a couple out but I did leave in the MHP one since that is necessary for word count.

Cory

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 12:34 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR

Hi Deb,

This is outstanding. Thank you and everyone else for this really nice and clear statement about suicide and its prevention. I have just a few general comments/suggestions:

1. One finding that you don't make much of, but I think is important, is that suicide rates across states are increasing faster for females relative to males. Overall, of course, this is a problem still dominated by males, but that appears to be changing. And that's not surprising in terms of societal changes around gender roles and norms. I realize you can't highlight everything, but that is very interesting and may signal a longer term trend that's worth noting.
2. You may have to cut back the word number some and if you do I think you can get away without the second sentence in the results that focusses on absolute changes in rates. People understand the meaning of % changes much easier, so no biggie, but that could be dropped if needed.

3. In regards to the first sentence in the last paragraph, I wondering if the last clause could be changed to "…, but is only one of several…" If we say one of "many" then the argument is that we can't focus on everything so we should focus on the most important risk factor. I'm not wedded to this, but clearly we are emphasizing the need to focus on factors beyond mental illness (but not excluding mental illness) and I think this sentence could be made a little stronger in support of that, especially because it ties things up at the end.

Thanks that is all I had. Thanks so much and can't wait until this comes out.

Jim

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 8:14 AM
To: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: Pre-clearance Draft of Suicide Vital Signs MMWR
Importance: High

Hi Jim, Cory, Erin, and Malia,
Just a friendly reminder to please send your feedback on the MMWR by COB today. Your time and insights are greatly appreciated!
Deb
*****

Hi Everyone,
Please find attached a draft of our suicide Vital Signs MMWR for pre-clearance.
Thank you for previously agreeing to review it with a quick turnaround of COB 3/22.
We are still working out one outstanding issue—whether to report percentages and/or aORs pertaining to NVDRS results.
Right now we opt for percentages however we may also include aOR and CI's.
Please send your edits in tracked changes. If you have any questions, please let me know.
We look forward to your feedback! And thanks to the whole team for a whole lot of time, thought, and expertise dedicated to this draft!
Thanks again!
Deb

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Through Science and Action

Rev 3.19.18 v3

Short title: Vital Signs: Increasing Trends in State Suicide Rates and Contributing Circumstances

Deborah M. Stone, ScD;[1] Thomas R. Simon PhD;[1] Katherine A. Fowler, PhD;[1] Scott R. Kegler, PhD;[2] Keming Yuan, MS;[1] Kristin M. Holland, PhD;[1] Asha Z. Ivey-Stephenson, PhD;[1] Alex E. Crosby, MD[1]

Structured abstract (256252/250 words—this word count is not included in the 1800 max for the remainder)

Background: Overall sSuicide rates have been rising in the United States since 1999. Examining state-level trends in suicide and its multiple contributing circumstances, can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates, by state and sex, among people aged ≥10 years, were assessed using data from the National Vital Statistics System. Changes in rates were examined across six consecutive three-year periods from 1999-2016. TheCDC's National Violent Death Reporting System (2015), covering 27 states, was used to examine the precipitating circumstances among suicide decedents with and without known mental health problems (MHP).

Results: Forty-four states saw statistically significant sSuicide rates increases increased significantly from 1999-2016 in 44 states. In 25 states, rates increased by 30% or more. Male suicide rates increased significantly in 34 states. while fFemale rates increased significantly in 43 states. People with (46%) and without (54%) known MHP had both differing and similar circumstances precipitating suicide. Several circumstance, such as any relationship problems/loss (39.6 and 45.1%, $p \leq .01$), any life stressors/loss (49.7 and 54.2%, $p \leq .01$), and recent crises (26.0 and 32.9%, $p \leq .01$), respectively, were more likely among those without known MHP, but were common across groups.

Conclusions: Suicide rates rose significantly across most states from 1999-2016. Varied circumstances beyond MHP alone contributed to suicides among people with and without known MHP.

Implications for Public Health Practice: States can use a comprehensive public health approach based on the best available evidence to prevent suicide risks before they occur, identify and support people already at risk, prevent reattempts, and help friends/family after a suicide occurs.

INTRODUCTION

BACKGROUND AND PURPOSE (255/260 words)

In 2016, nearly 45,000 suicides (15.6/100,000) occurred in the United States (U.S.), among people ≥10 years old [1]. Between 1999 and 2016, suicide rates increased across sexes, racial/ethnic groups, and urbanization levels [2, 3]. Suicide is the 10th leading cause of death and is among the only leading causes to be *increasing* [1, 4]. Additionally, rates of Emergency Department visits for nonfatal self-harm injury, a key risk factor for suicide, increased more than 40% between 2001 and 2015 [1]. Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs [1].

The *National Strategy for Suicide Prevention(NSSP)* [5] calls for a public health approach to suicide with prevention with efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal), of the social ecology. Such an approach underscores that suicide is rarely caused by any single factor alone, but rather, is multi-determined. Despite the NSSP guidance, suicide prevention efforts largely focus on identifying and treating individuals with mental health problems (MHP) [6]. Other associated contributing risk factors include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, poor coping and problem-solving skills, and prior suicide attempts, among others [5]. Expanded

Comment [BE(]: Sometimes it is referred to as a 'contributing circumstance' and sometimes its referred to as a 'contributing factor'. I wonder if its

Comment [FC(]: Can a couple of words be added here to reflect a date since rates have been rising. I see word count is an issue and I think a couple of words can

Comment [FC(]: Style consideration. Since focus on suicide and states is clear, may not these words twice in sentence which would reduce word count. A few

Comment [FC(]: The transition from reading NVDRS covers 27 states to methods to the first line in the results referring to 44 states made me pause and

Comment [FC(]: Unclear if this was supposed to be a reference or can come out.

Comment [JRV8]: Just a suggestion and may not be feasible, but would suggest not using MHP through the document. Mental health problems doesn't seem

Comment [BE(]: I think this is a Significant finding should we say more about it the fact that it is increasing more in women?

Comment [FC(]: I think edits are needed here for a few reasons. I am finding the statements that there are differences and similarities vague and hard to follow

Comment [FC(]: Please double check. I am getting 15.9 from WISQARS

Comment [BE(]: Can we be more specific – is it the only or is it one of only X leading causes increasing – 'among the only' is vague?

Comment [FC(]: Please double check. Wonder if this might have been calculated for all ages and not limited to ≥10 years.

Comment [JRV8]: Suggest identifying this as a US Surgeon General report.

Comment [BE(]: Is it better to say social ecology (which I think many think of social, environmental and economic) versus I think what is used most often the

awareness of the additional circumstances that contribute to suicide risk apart from MHP, can help reach the nation's goal of reducing suicide rates 20% by 2025 [7]. To assist states in achieving this goal, this study analyzes state-specific trends in suicide rates, assesses the multiple contributing factors ~~associated with suicide~~, and provides recommendations for multi-level comprehensive suicide prevention.

METHODS (257/260 words)

Suicide rates were analyzed for those aged 10 years and older (because of variability in attributions of suicidal intent, younger children are excluded) [8]. Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases 10th Revision* [ICD-10] underlying-cause-of death codes X60-X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive three-year aggregate periods from 1999-2016. Rate estimates were age-adjusted to the U.S. year 2000 standard population and expressed per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same three-year data aggregates, employing weighted least squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes (AAPCs).

Data from 2015 from the 27 states with complete data participating in ~~the~~CDC's National Violent Death Reporting System (NVDRS), ages 10 and older, were used to compare the characteristics among suicide decedents with and without known current ~~mental health problems~~ (MHP). MHP are defined in NVDRS as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [9], except alcohol and other substance use disorders (captured separately). NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. Decedents with and without known MHP were compared using Chi-square tests; logistic regression was used to estimate adjusted odds ratios with 95% confidence intervals (CI), controlling for age group, sex, and race/ethnicity.

RESULTS (612/591 words)

The most recent overall suicide rates (representing 2014-2016) ranged from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year, a four-fold difference (Table 1). Across the entire study period, rates increased in all but one state (Nevada), with absolute increases ranging from +0.2 (Delaware) to +8.1 (Wyoming) per 100,000. Percentage increases in rates ranged from +5.9% (Delaware) to +57.6% (North Dakota), with percentage increases of at least 30% observed in 25 states.

Modeled suicide rate trends indicated significant increases for 44 states, as well as for the U.S. overall (Table 1). By sex, modeled rate trends indicated significant increases in 34 states for males and in 43 states for females. Nationally, the model-estimated AAPC for the overall suicide rate was +1.5%. By sex, the national AAPC was +1.1% for males and +2.6% for females.

Suicide decedents with (N=9,407) and without (N=11,039) known MHP were compared. ~~While b~~Both groups were predominately male and non-Hispanic white. ~~, s~~Suicide decedents without known MHP relative to those with known MHP were more likely to be male (83.6% vs. 68.8%; p≤.01), and racial/ethnic minorities (odds ratio [OR] range: 1.2-2.1; 95% CI range [1.0-1.3] – [1.6-2.0]). ~~They~~Suicide decedents without known MHP also had significantly greater odds of perpetrating homicide-suicide (adjusted odds ratio [aOR] = 2.9, 95% CI = 2.2-3.8), of firearm suicide (aOR = 1.6, 95% CI = 1.5-1.7), and of positive toxicology results for alcohol (aOR = 1.2, 95% CI = 1.1-1.3). Fifteen percent of ~~those~~adult decedents with known MHP, and 20% without, ~~ever~~ had served or were serving ~~served~~ in the U.S. military.

Comment [BE(]: Is it really the 'nation's goal' – versus the goal set by the American Foundation for Suicide Prevention.

Comment [JRV8]: Sentence has a lot of different points. It may be easier to read if it were two sentences. Suggestion:

Data from the National Violent Death Reporting System (NVDRS) were used to compare characteristics among suicide decedents with and without known current mental health programs. Complete data from 27 states participating in NVDRS in 2015 were used for this analyses.

Comment [FC(]: I am confused by how the alcohol and substance use disorder exception is described. DSM-5 does have an alcohol use disorder diagnosis and a substance use disorder dx.

Comment [FC(]: Some labeling of the tables and how reflected in the text need some modification. There are current two "Table 1" in attachments (i.e., state trends; select demographics). The two NVDRS tables and figure 1 don't appear to

Comment [BE(]: Per our discussion in our last VS group meeting, should we add a note that despite NV not increases, they still have a significantly high rate of suicide?

Comment [FC(]: Please double check. Table reflects +0.8

Comment [FC(]: Suggest revising in order to allow in the next sentence the comparison group to be clear and the order the %'s should be considered clearer. Tracked is an idea.

Comment [FC(]: Wonder if need to be clear here this is limited to 18+. Tracked might be a simple approach to consider.

I have seen MMWR want to present %'s to first decimal place consistently. Here is

Comment [JRV8]: I realize this adds words so you may not be able to do this but the "ever" in the original sentence was confusing/stumbling block to me as a I read. Not sure if the additional language is correct – vets and active duty or just

Although firearms were used most often in both groups, decedents with known MHP died by poisoning more than those without known MHP (19.8% vs. 10.4%; $p \leq .01$), most frequently by over-the-counter/otherwise unclassified drugs (35.8%), opioids (32.7%), antidepressants (34.6%) or benzodiazepines (25.1%).

All suicide decedents with known MHP (N=9,407) and approximately 85% without (N=9,357) had precipitating circumstances ~~information~~ (Table 2 or 3??). People with known MHP were more likely to have any substance abuse problems (31.6% vs. 25%, $p \leq .01$). While two-thirds of those with known MHP had a history of MH or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment at the time of their deaths.

Decedents without known MHP, versus those with known MHP had a greater likelihood of any relationship problem/loss (45.1% ~~and~~vs. 39.6%, $p \leq .01$), specifically intimate partner problems (30.2% ~~and~~vs. 24.1%, $p \leq .01$), arguments/conflicts (17.5% ~~and~~vs. 13.6%, $p \leq .01$), and recently perpetrating interpersonal violence (3.0% ~~and~~vs. 1.4%, $p \leq .01$). They were also more likely to have experienced other life stressors, such as criminal-legal problems (10.7% ~~and~~vs. 6.2%, $p \leq .01$) or eviction/loss of home (4.3% ~~and~~vs. 3.4%, $p \leq .01$), and they were more likely to have had a crisis within the preceding or upcoming two weeks (32.9% ~~and~~vs. 26.0%, $p<.01$). Among both groups, the most common crises were intimate partner (35.6%) and physical health (13.4%) problems.

Decedents without known MHP had significantly lower odds of recent release from any institution, but among those who were recently released, those without a known MHP were more likely to be released from a correctional facility (25.7% vs. 8.7%, $p \leq .01$) or hospital (43.7% vs. 33.0%, $p \leq .01$) than those with a known MHP. Among decedents with known MHP recently released from an institution (10.2%), 42.8% were released from psychiatric facilities.

Suicide decedents without known MHP were more likely than those without known MHP to leave a suicide note (35.1% ~~and~~vs. 31.8%, $p \leq .01$). ~~while d~~Decedents with known MHP, compared to those without known MHP, were more likely to have a history of suicidal ideation (40.8% vs. 23.0%, $p \leq .01$) and attempts (29.4% vs. 10.3%, $p \leq .01$).

Conclusions and Comments (655/715 words)

From 1999-2016, 44 states saw significant suicide rate increases. Half of the states experienced increases of 30% or more. Rates increased significantly in 34 states among males and 43 states among females. More research into the causes of these trends is necessary [10].

One important factor associated with suicide is MHP. Nearly half of suicide decedents in NVDRS had a known MHP. This group was challenged by comorbid substance abuse problems (31.6%) and histories of suicidal ideation (40.8%) and attempts (29.4%). While two-thirds of people with known MHP had a history of MH and/or substance abuse treatment and over half were in treatment at the time of their deaths, additional support ~~could~~ may help address the needs of this vulnerable population. This includes broader implementation of affordable and evidence-based treatments, such as doctor-patient collaborative care models and cognitive-behavioral therapy. Additionally, greater access to behavioral health providers, especially in underserved areas is important, as is healthcare systems ~~change~~ that supports suicide prevention and patient safety through care transitions [11].

While mental health problems are a significant contributor to suicide, 54% of suicide decedents in this study did *not* have a known MHP. This group suffered more relationship problems and life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises. This is noteworthy in light of findings that suggest many suicides and attempts occur with minimal deliberation time, particularly among people without mental health disorders and who faced impending life crises [12].

Comment [FC(]: I think the comparison group %'s are needed. For instance, drugs (35.8% vs. 35.8%).

I think the presentation of the %'s would be easier here and later on in the results if the p's came out and the text could simply reflect "significant differences" or some variation of indicating in the groups were different.

Comment [BE(]: Sometimes criminal-legal is hyphenated and sometimes it's not.

Comment [FC(]: The % reported in this sentence appear to be only for the group with MHPs. Based on the sentence wording, the % for both groups need to be reported.

Comment [FC(]: Please double check number. Table reflects 33.8%

Comment [FC(]: My two cents: I think we should do more to raise attention to the fact that almost a quarter of both groups disclosed suicide intent. This is a true prevention opportunity so I think this is a common risk to highlight. Knowing space constraints, I think this is more important to highlight than the presence of a suicide note which often doesn't inform prevention. I suggest adding into results and into discussion.

Comment [FC(]: I feel that MMWRs typically don't do a lot of repeat of the specific data findings in the discussion. I think the numbers could come out here. I think it would be helpful to put this into a larger context, indicating whether this is consistent with other research. I also

Comment [BE(]: I would add the percentage in parenthesis (X%).

People with known MHP also experienced other life stressors such as job and/or financial~~, problems,~~ relationship ~~problems~~, and/or physical health problems. These findings point to the need to both prevent the conditions associated with mental health problems in the first place and the need to support people with known MHP to decrease their vulnerability to poor social, health, and economic outcomes [13].

These results underscore the importance of comprehensive statewide suicide prevention activities that go beyond a focus on ~~MH~~mental health treatment alone. Prevention strategies may include: strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills, especially early in life to manage everyday stressors and prevent future relationship problems; and promoting social connectedness to increase a sense of belongingness and access to informational, tangible, emotional, and social support~~, as needed~~. Other strategies ~~indicated by these results~~ include creating protective environments (e.g., reducing access to lethal means among people at risk, creating organizational and workplace policies to promote help-seeking and positive social norms), supporting family and friends after a suicide ~~has taken place~~, and assuring safe reporting by the media in order to prevent suicide contagion [11]. Some states, such as Colorado, are planning and implementing a comprehensive statewide approach to suicide prevention [14].

The ~~study~~ findings have at least three limitations. In the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent, or by decreased percentages of such deaths over time, which likely include some unrecognized suicides. Second, NVDRS is not yet nationally representative, and this study's ~~. This study used the most current data available which~~ data include~~des~~ 27 states that represent ~~half (~~49.6%~~)~~ of the U.S. population. Third, abstractors of NVDRS data are limited to data included in investigative reports. ~~For example, m~~Medical and ~~MH~~mental health information ~~are not captured directly from medical records but~~ come from key informants (e.g., family, friends) via coroner/medical examiner reports and can ~~. Therefore, informant knowledge~~ impact~~s~~ the data completeness and accuracy~~, of the information reported, and~~ Some studies including in-depth interviews with family members show ~~often see~~ greater attributions to ~~MH~~mental health and substance abuse disorders than medical records~~, however methodological variation across studies exists~~ [15]. It is likely that some people without known MHP in the current study were experiencing mental health challenges at the time of death that were either not known or reported by informants~~, or were not captured in NVDRS's primary data sources. The lack of awareness of a mental health problem suggests the importance of addressing the range of contributing circumstances~~.

Suicide is a growing public health problem. Mental illness is an important risk factor for suicide, and is one of many requiring preventive action. Data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices* [11] can help states and communities better understand their suicide problem and prioritize comprehensive suicide prevention.

Acknowledgments
The authors acknowledge Robert Anderson, Holly Hedegaard, and Margaret Warner from the Division of Vital Statistics, National Center for Health Statistics, CDC, for their statistical consultation.

Conflict of Interest No conflicts of interest were reported.

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Author Affiliations:

Comment [FC(]: I suggest pulling this out into a separate paragraph. If contained in the above, it seems to undercut the main point that many suicides don't have MPH. A new paragraph might need a lead-in sentence or maybe start with the current last sentence to frame points about common risks.

Comment [BE(]: Should this be 'and', 'or' or 'and/or'?

Comment [JRV8]: Suggest using "risk of" rather than "vulnerability to", as vulnerability sometimes can have negative connotations aligned with weakness.

Comment [FC(]: I think it is fine that the TP strategies are presented in different areas of the discussion. I don't easily see "identify and support people at-risk". I think that can go in the proposed paragraph immediately above when talking about common risk factors. In adding that, suggest adding some examples of approaches (e.g., crisis intervention, gatekeeper training).

Comment [FC(]: I am not easily following this point. Can this be stated more simply such as "…impacted by variations of undetermined injury deaths, which likely….

To help w/word count, offer a couple of suggestions in next few sentences to streamline. Certainly take/leave what you like and check for accuracy.

Comment [BE(]: Do you mean 'NOT' reported by informants?

Comment [FC(]: To me, this sentence puts the spotlight back on mental illness and makes it likely it will be the take home message of media reporting. If that isn't the goal of this VS, suggest framing broadly. Ideas: *Effective approaches are available to prevent or ameliorate many*

[1]Division of Violence Prevention, National Center for Injury Prevention and Control, CDC; [2]Division of Analysis, Research, and Practice Integration, National Center for Injury Prevention and Control, CDC

References:

1. Centers for Disease Control and Prevention, *Web-based Injury Statistics Query and Reporting System (WISQARS). Atlanta, GA: National Center for Injury Prevention and Control. Retrieved March 15, 2018*. 2016.
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12. Simon, T.R., et al., *Characteristics of impulsive suicide attempts and attempters.* Suicide and Life-Threatening Behavior, 2002. **32**(s1): p. 49-59.
13. World Health Organization, *Risks to mental health: An overview of vulnerabilities and risk factors.* Geneva: WHO, 2012.
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15. Hawton, K., et al., *The psychological autopsy approach to studying suicide: a review of methodological issues.* J Affect Disord, 1998. **50**(2-3): p. 269-76.

Tables and Figures (attachments)

Table 1 and Figure 1.doc

Tables 2 and 3.pdf

Word Count: 1826/1800

DRAFT

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 22 Mar 2018 15:25:15 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Ferdon, Corinne (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR
Attachments: Copy of Tables (23) Suicide Vital Signs NVDRS_031918 (pre-clearance)_CF.....xlsx, MMWR Table 1 and Figure 1_CF.DOCX, Suicide Vital Signs MMWR Text 3.19.18 v3 (pre-clearance)_CF_EB.docx

FABULOUS job Deb! This was very exciting and compelling to read! Congratulations on this huge milestone!
I agree with Jim's comment about emphasizing more the increase in female vs. male rates. I also provided some mostly editorial questions/comments and suggested edits in track changes summarized below:

- Sometimes it is referred to as a 'contributing circumstance' and sometimes its referred to as a 'contributing factor'. I wonder if its best to be consistent so as not to confuse the reader that the two are different. From a plain language perspective, I prefer contributing factors? Also, sometimes it is referred to a just 'contributing factor' while other times it is referred to as 'contributing risk factor'. Also, sometime it is referred to as 'contributing' and sometimes as 'associated'. Should we be consistent?
- "Suicide is the 10th leading cause of death and is among the only leading causes to be *increasing*." Can we be more specific – is it the only or is it only one of 2 (e.g.) leading causes increasing – 'among the only' is vague?
- Is it better to say the current 'social ecology' (which I think many think of social, environmental and economic) versus I think what is used most often the 'social ecological model' (individual, family/relationship, community, and societal).
- "can help reach the nation's goal of reducing suicide rates 20% by 2025" – is it really the 'nation's goal' – versus the goal set by the American Foundation for Suicide Prevention.
- "Across the entire study period, rates increased in all but one state (Nevada)." Per our discussion in our last VS group meeting, should we add a note that despite NV not increasing, they still have a significantly high rate of suicide?
- Sometimes criminal-legal is hyphenated and sometimes it's not.
- "Nearly half of suicide decedents in NVDRS had a known MHP." I would add the actual percentage in parenthesis (X%).
- People with known MHP also experienced other life stressors such as job and/or financial, relationship, and/or physical health problems. Should this be 'and', 'or' or 'and/or'?
- "It is likely that some people without known MHP in the current study were experiencing mental health challenges at the time of death that were either not known or reported by informants." Do you mean 'NOT' reported by informants?

From: Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 2:25 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR

Deb,
Congratulations to you and the entire vital signs writing team to getting to this point! It is an enormous achievement. I really like the direction the analyses have gone in. I know there is a considerable amount of work ahead, but you have a solid platform to build on.
I offer in the attachments some suggestions. Track changes are not easily done in the excel file so I highlight words in red to draw your attention to things to consider. In the text, I think there are a few numbers to double check, a few data points and clarifications to be added in, and the references to the tables/figure adjusted. I do like the balance that is currently in there on the %'s versus aORs.
Mental health problems as a driver of suicide jumped out to me as one of the main messages since the text kept coming back to it. I think there are some subtle reorganization or broader phrasing that could be used in some places to modify this if the communication goal is different; I offer some ideas in comment boxes. I recognize that I am suggesting adding some clarifying text in some places and word count is always an issue, so I did try to identify some places to potentially cut. Please review this as suggestions and take/leave what feels right.
FYI, in a meeting I was in with the MMWR editors yesterday they said they prefer little to no use of acronyms. So, in a few places I suggest taking a couple out but I did leave in the MHP one since that is necessary for word count.
Cory

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 12:34 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR

Hi Deb,
This is outstanding. Thank you and everyone else for this really nice and clear statement about suicide and its prevention. I have just a few general comments/suggestions:

1. One finding that you don't make much of, but I think is important, is that suicide rates across states are increasing faster for females relative to males. Overall, of course, this is a problem still dominated by males, but that appears to be changing. And that's not surprising in terms of societal changes around gender roles and norms. I realize you can't highlight everything, but that is very interesting and may signal a longer term trend that's worth noting.
2. You may have to cut back the word number some and if you do I think you can get away without the second sentence in the results that focusses on absolute changes in rates. People understand the meaning of % changes much easier, so no biggie, but that could be dropped if needed.
3. In regards to the first sentence in the last paragraph, I wondering if the last clause could be changed to "..., but is only one of several..." If we say one of "many" then the argument is that we can't focus on everything so we should focus on the most important risk factor. I'm not wedded to this, but clearly we are emphasizing the need to focus on factors beyond mental illness (but not excluding mental illness) and I think this sentence could be made a little stronger in support of that, especially because it ties things up at the end.

Thanks that is all I had. Thanks so much and can't wait until this comes out.
Jim

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 8:14 AM
To: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC)

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Subject: Pre-clearance Draft of Suicide Vital Signs MMWR
Importance: High

Hi Jim, Cory, Erin, and Malia,
Just a friendly reminder to please send your feedback on the MMWR by COB today. Your time and insights are greatly appreciated!
Deb
*****
Hi Everyone,
Please find attached a draft of our suicide Vital Signs MMWR for pre-clearance.
Thank you for previously agreeing to review it with a quick turnaround of COB 3/22.
We are still working out one outstanding issue—whether to report percentages and/or aORs pertaining to NVDRS results.
Right now we opt for percentages however we may also include aOR and CI's.
Please send your edits in tracked changes. If you have any questions, please let me know.
We look forward to your feedback! And thanks to the whole team for a whole lot of time, thought, and expertise dedicated to this draft!
Thanks again!
Deb

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Table 1. Select Demographic and Descriptive Characteristics of Suicides among Decedents >10 years of age with and without Known Mental Health Problems--National Violent Death Reporting System, 27 states*, 2015

Characteristics	Total (n=20,446)	Known Mental Health Problem† (n=9,407)	No Known Mental Health Problem (n=11,039)	Chi-Square	OR (95% CI)	Adjusted OR§ (95% CI)
Sex						
Male	15,702(76.8)	6,469(68.8)	9,233(83.6)	p<.01	2.3(2.2-2.5)	
Female	4,744(23.2)	2,938(31.2)	1,806(16.4)	p<.01	0.4(0.4-0.5)	
Age¶						
10-24	2,804(13.7)	1,211(12.9)	1,593(14.4)	p<.01	1.1(1.1-1.2)	
25-44	6,456(31.6)	3,036(32.3)	3,420(31.0)	p<.05	0.9(0.9-1.0)	
45-64	7,718(37.7)	3,820(40.6)	3,898(35.3)	p<.01	0.8(0.8-0.8)	
65+	3,468(17.0)	1,340(14.2)	2,128(19.3)	p<.01	1.4(1.3-1.5)	
Race/ethnicity						
White, non-Hispanic	17,102(83.6)	8,165(86.8)	8,937(81.0)	p<.01	0.6(0.6-0.7)	
Black, non-Hispanic	1,228(6.0)	411(4.4)	817(7.4)	p<.01	1.7(1.5-2.0)	
American Indian/Alaska Native, non-Hispa	378(1.8)	112(1.2)	266(2.4)	p<.01	2.0(1.6-2.6)	
Asian, non-Hispanic	576(2.8)	235(2.5)	341(3.1)	p<.05	1.2(1.1-1.5)	
Hispanic	1,096(5.4)	463(4.9)	633(5.7)	p<.05	1.2(1.0-1.3)	
Other	66(0.3)	21(0.2)	45(0.4)	p<.05	1.8(1.1-3.1)	
Extended demographics						
Ever served in military**	3,429(17.8)	1,354(15.3)	2,075(20.1)	p<.01	1.4(1.3-1.5)	1.1(1.0-1.1)
Homeless	240(1.2)	104(1.1)	136(1.3)		1.1(0.9-1.5)	1.2(0.9-1.5)
Incident Type						
Homicide followed by suicide	319(1.6)	64(0.7)	255(2.3)	p<.01	3.5(2.6-4.5)	2.9(2.2-3.8)
Single suicide	20,063(98.2)	9,318(99.1)	10,745(97.4)	p<.01	0.3(0.3-0.4)	0.4(0.3-0.5)
Method						
Firearm	9,909(48.5)	3,821(40.6)	6,088(55.3)	p<.01	1.8(1.7-1.9)	1.6(1.5-1.7)
Hanging/Strangulation/Suffocation	5,907(28.9)	2,940(31.3)	2,967(26.9)	p<.01	0.8(0.8-0.9)	0.8(0.7-0.8)
Poisoning	3,003(14.7)	1,861(19.8)	1,142(10.4)	p<.01	0.5(0.4-0.5)	0.6(0.6-0.7)
Substance class causing death††						
Other (e.g., over-the-counter)	1,021(34.0)	666(35.8)	355(31.1)	p<.01	0.8(0.7-0.9)	0.9(0.7-1.0)
Opioids	944(31.4)	608(32.7)	336(29.4)		0.9(0.7-1.0)	0.9(0.8-1.1)
Antidepressants	800(26.6)	644(34.6)	156(13.7)	p<.01	0.3(0.2-0.4)	0.3(0.3-0.4)
Benzodiazepines	624(20.8)	468(25.1)	156(13.7)	p<.01	0.5(0.4-0.6)	0.5(0.4-0.6)
Antipsychotics	219(7.3)	195(10.5)	24(2.1)	p<.01	0.2(0.1-0.3)	0.2(0.1-0.3)
Other	1,595(7.8)	780(8.3)	815(7.4)	p<.05	0.9(0.8-1.0)	0.9(0.8-1.0)
Toxicology Results						
Any toxicology testing	13,317(65.1)	6,658(70.8)	6,659(60.3)	p<.01	0.6(0.6-0.7)	0.7(0.6-0.7)
Positive for ≥ 1 substance§§	9,913(74.4)	5,192(78.0)	4,721(70.9)	p<.01	0.7(0.6-0.7)	0.8(0.7-0.8)
Substance detected***						
Alcohol						
Tested	10,950(53.6)	5,409(57.5)	5,541(50.2)	p<.01	0.7(0.7-0.8)	0.8(0.7-0.8)
Positive	4,442(40.6)	2,115(39.1)	2,327(42.0)	p<.01	1.1(1.0-1.2)	1.2(1.1-1.3)
Opioids						
Tested	8,554(41.8)	4,258(45.3)	4,296(38.9)	p<.01	0.8(0.7-0.8)	0.8(0.8-0.9)
Positive	2,279(26.6)	1,238(29.1)	1,041(24.2)	p<.01	0.8(0.7-0.9)	0.9(0.8-1.0)
Benzodiazepines						
Tested	8,124(39.7)	4,226(44.9)	3,898(35.3)	p<.01	0.7(0.6-0.7)	0.7(0.7-0.8)
Positive	2,464(30.3)	1,639(38.8)	825(21.2)	p<.01	0.4(0.4-0.5)	0.5(0.5-0.6)
Cocaine						
Tested	7,978(39.0)	3,866(41.1)	4,112(37.2)	p<.01	0.9(0.8-0.9)	0.9(0.9-1.0)
Positive	499(6.3)	216(5.6)	283(6.9)	p<.05	1.2(1.0-1.5)	1.2(1.0-1.5)
Amphetamines						
Tested	7,615(37.2)	3,696(39.3)	3,919(35.5)	p<.01	0.9(0.8-0.9)	0.9(0.8-0.9)
Positive	736(9.7)	376(10.2)	360(9.2)		0.9(0.8-1.0)	1.0(0.8-1.1)
Marijuana						
Tested	6,569(32.1)	3,127(33.2)	3,442(31.2)	p<.01	0.9(0.9-1.0)	0.9(0.9-1.0)
Positive	1,471(22.4)	710(22.7)	761(22.1)		1.0(0.9-1.1)	0.9(0.8-1.0)
Antidepressants						
Tested	5,425(26.5)	3,103(33.0)	2,322(21.0)	p<.01	0.5(0.5-0.6)	0.6(0.6-0.7)
Positive	2,214(40.8)	1,735(55.9)	479(20.6)	p<.01	0.2(0.2-0.2)	0.2(0.2-0.3)

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey,

† Decedent had been identified as currently having a diagnosed mental health problem in coroner/medical examiner or law enforcement reports.

§ Logistic regression was used to estimate adjusted odds ratio with 95% CIs after controlling for age, sex, race and ethnicity.

¶ Decedents were aged 10 years and older, as per standard in the suicide prevention literature.

** Denominator is decedents aged 18 years of age and older with reported military service status.

†† Denominator is decedents who died by poisoning, including overdose.

§§ Denominator is decedents with any toxicology tested.

*** Denominator for each positive group is the number tested for the substance in that group.

is an additional footnote needed on total or on the categories below to reflect why some don't add up to the overall total (e.g., age, incident type)

"single suicide" made me wonder about simultaneous or related suicides (ie more than one person), especially given this is available in NVDRS. Wonder if need another category for murder/related suicides or if the suicide suicide category should be renamed.

Considerable on both excel tables. "Currently having" feels odd to me since the individual is deceased. Could modify to something "having a current diagnosed mental health problem at time of death..."
Also think on both table examples or how MHP is defined is needed in the footnote to help the tables be interpretable independently from text

Table 2. Circumstances Preceding Suicide among Decedents ≥10 years of age with and without Known Mental Health Problems--National Violent Death Reporting System, 27 states*, 2015

Characteristics	Total	Known Mental Health Problem†	No Known MH Problem	Chi-Square	OR (95% CI)	Adjusted OR§ (95% CI)
Suicide with known circumstances	18,764(91.8)	9,407(100)	9,357(84.8)	p<.01		
Mental Health/Substance Problems						
Any Current Mental Health Diagnosis¶						
Depression/dysthymia	7,076(75.2)	7,076(75.2)				
Anxiety disorder	1,579(16.8)	1,579(16.8)				
Bipolar disorder	1,431(15.2)	1,431(15.2)				
Schizophrenia	509(5.4)	509(5.4)				
PTSD	424(4.5)	424(4.5)				
ADD/ADHD	226(2.4)	226(2.4)				
Unknown	760(8.1)	760(8.1)				
Current depressed mood	7,038(37.5)	3,962(42.1)	3,076(32.9)	p<.01	0.7(0.6-0.7)	0.7(0.6-0.7)
Substance Problems						
Any Current substance problem	5,319(28.3)	2,976(31.6)	2,343(25.0)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Alcohol problem	3,268(17.4)	1,862(19.8)	1,406(15.0)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Other substance problem	3,084(16.4)	1,768(18.8)	1,316(14.1)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Treatment						
Current mental health/substance abuse treatment	5,141(27.4)	5,077(54.0)	64(0.7)	p<.01	0.0(0.0-0.0)	0.0(0.0-0.0)
Ever treated for metnal health/substance problem	6,717(35.8)	6,323(67.2)	394(4.2)	p<.01	0.0(0.0-0.0)	0.0(0.0-0.0)
Relationship Problems/Loss						
Any relationship problem/loss	7,948(42.4)	3,726(39.6)	4,222(45.1)	p<.01	1.3(1.2-1.3)	1.3(1.2-1.4)
Intimate partner problem	5,098(27.2)	2,270(24.1)	2,828(30.2)	p<.01	1.4(1.3-1.5)	1.4(1.3-1.5)
Perpetrator of interpersonal violence past month	414(2.2)	131(1.4)	283(3.0)	p<.01	2.2(1.8-2.7)	2.0(1.6-2.4)
Victim of interpersonal violence within past month	84(0.4)	53(0.6)	31(0.3)	p<.05	0.6(0.4-0.9)	0.8(0.5-1.2)
Family relationship problem	1,671(8.9)	873(9.3)	798(8.5)		0.9(0.8-1.0)	1.0(0.9-1.1)
Other relationship problem (non-intimate)	403(2.1)	202(2.1)	201(2.1)		1.0(0.8-1.2)	1.1(0.9-1.3)
Argument or conflict (not specified)	2,914(15.5)	1,278(13.6)	1,636(17.5)	p<.01	1.3(1.2-1.5)	1.4(1.3-1.5)
Death of a loved one (any)	1,497(8.0)	826(8.8)	671(7.2)	p<.01	0.8(0.7-0.9)	0.9(0.8-0.9)
Non-suicide death	1,181(6.3)	647(6.9)	534(5.7)	p<.01	0.8(0.7-0.9)	0.9(0.8-1.0)
Suicide of family or friend	379(2.0)	217(2.3)	162(1.7)	p<.01	0.7(0.6-0.9)	0.8(0.7-1.0)
Other Life Stressors/Loss						
Any life stressors/loss	9,743(51.9)	4,675(49.7)	5,068(54.2)	p<.01	1.2(1.1-1.3)	1.1(1.1-1.2)
Recent criminal legal problem	1,588(8.5)	586(6.2)	1,002(10.7)	p<.01	1.8(1.6-2.0)	1.7(1.5-1.9)
Other legal problem	748(4.0)	378(4.0)	370(4.0)		1.0(0.8-1.1)	1.0(0.9-1.2)
Physical health problem	4,179(22.3)	2,012(21.4)	2,167(23.2)	p<.01	1.1(1.0-1.2)	1.0(1.0-1.1)
Job/Financial problem**	2941(16.2)	1530(16.8)	1411(15.6)	p<.05	0.9(0.8-1.0)	0.9(0.8-1.0)
Eviction or loss of home	722(3.8)	317(3.4)	405(4.3)	p<.01	1.3(1.1-1.5)	1.4(1.2-1.6)
School problem††	162(19.9)	70(17.8)	92(21.9)		1.3(0.9-1.8)	1.3(0.9-1.9)
Recent release from an institution§§	1,412(7.6)	941(10.2)	471(5.1)	p<.01	0.5(0.4-0.5)	0.5(0.4-0.5)
Jail/prison/detention facility	203(14.4)	82(8.7)	121(25.7)	p<.01	3.6(2.7-4.9)	4.5(3.2-6.4)
Hospital	517(36.6)	311(33.0)	206(43.7)	p<.01	1.6(1.3-2.0)	1.3(1.0-1.7)
Psychiatric hospital	432(30.6)	403(42.8)	29(6.2)	p<.01	0.1(0.1-0.1)	0.1(0.1-0.1)
Other psychiatric institution	37(2.6)	36(3.8)	1(0.2)	p<.01	0.1(0.0-0.4)	—¶¶
Residential facility (alc/SA treat)	80(5.7)	50(5.3)	30(6.4)		1.2(0.8-1.9)	—¶¶
Other	143(10.1)	59(6.3)	84(17.8)	p<.01	3.2(2.3-4.6)	3.1(2.2-4.5)
Crisis within past or upcoming two weeks***	5,525(29.4)	2,444(26.0)	3,081(32.9)	p<.01	1.4(1.3-1.5)	1.4(1.3-1.5)
Intimate partner problem crisis	1968(35.6)	854(34.9)	1114(36.2)		1.1(0.9-1.2)	1.1(0.9-1.2)
Physical health problem crisis	739(13.4)	315(12.9)	424(13.8)		1.1(0.9-1.3)	1.0(0.8-1.2)
Criminal legal problem crisis	621(11.2)	203(8.3)	418(13.6)	p<.01	1.7(1.5-2.1)	1.6(1.3-1.9)
Family relationship problem crisis	430(7.8)	212(8.7)	218(7.1)	p<.05	0.8(0.7-1.0)	0.9(0.7-1.1)
Job problem crisis	354(6.4)	191(7.8)	163(5.3)	p<.01	0.7(0.5-0.8)	0.7(0.5-0.8)
Suicide Event/History						
Left a note	6,468(34.5)	3,182(33.8)	3,286(35.1)		1.1(1.0-1.1)	1.2(1.1-1.2)
Disclosed suicide intent	4,405(23.5)	2,306(24.5)	2,099(22.4)	p<.01	0.9(0.8-1.0)	0.9(0.8-0.9)
History of ideation	5,990(31.9)	3,838(40.8)	2,152(23.0)	p<.01	0.4(0.4-0.5)	0.4(0.4-0.5)
History of attempts	3,732(19.9)	2,770(29.4)	962(10.3)	p<.01	0.3(0.3-0.3)	0.3(0.3-0.3)

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as currently having a diagnosed mental health problem in coroner/medical examiner or law enforcement reports.

‡ Logistic regression was used to estimate adjusted odds ratio with 95% CIs after controlling for age, gender, race and ethnicity.

§ Includes decedents with one or more diagnosed current mental health problems, which are not mutually exclusive. Therefore sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health problems.

**Denominator is decedents aged 18 years of age and older.

†† Denominator is decedents aged 10-18 years.

§§ Denominator of institution subgroup is decedents with recent realease from an institution.

¶¶ Results are not reported. Model failed to converge due to data separation.

***Denominator of crisis subgroup is decedents with any crisis within past or upcoming two weeks. Crises depicted here represent the most commonly occurring categories.

Typo in "release". Is is possible to also describe what recent means? Past two week or is this quite variable? Given the broad audience of MMWR, can this be put into more simple terms?

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Differences between ranks do not necessarily imply a statistically significant difference.

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** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

Comment [FC(]: Wonder if in a revised title or footnote if it needs to be revised to reflect this also includes District of Columbia.

Comment [FC(]: Suggest being clear on what these period, similar to how done in another footnote.

Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

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Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

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		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

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State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Differences between ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first and last periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30)	+ 34.1 % (23)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3)	+ 46.5 % (4)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Differences between ranks do not necessarily imply a statistically significant difference.

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†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

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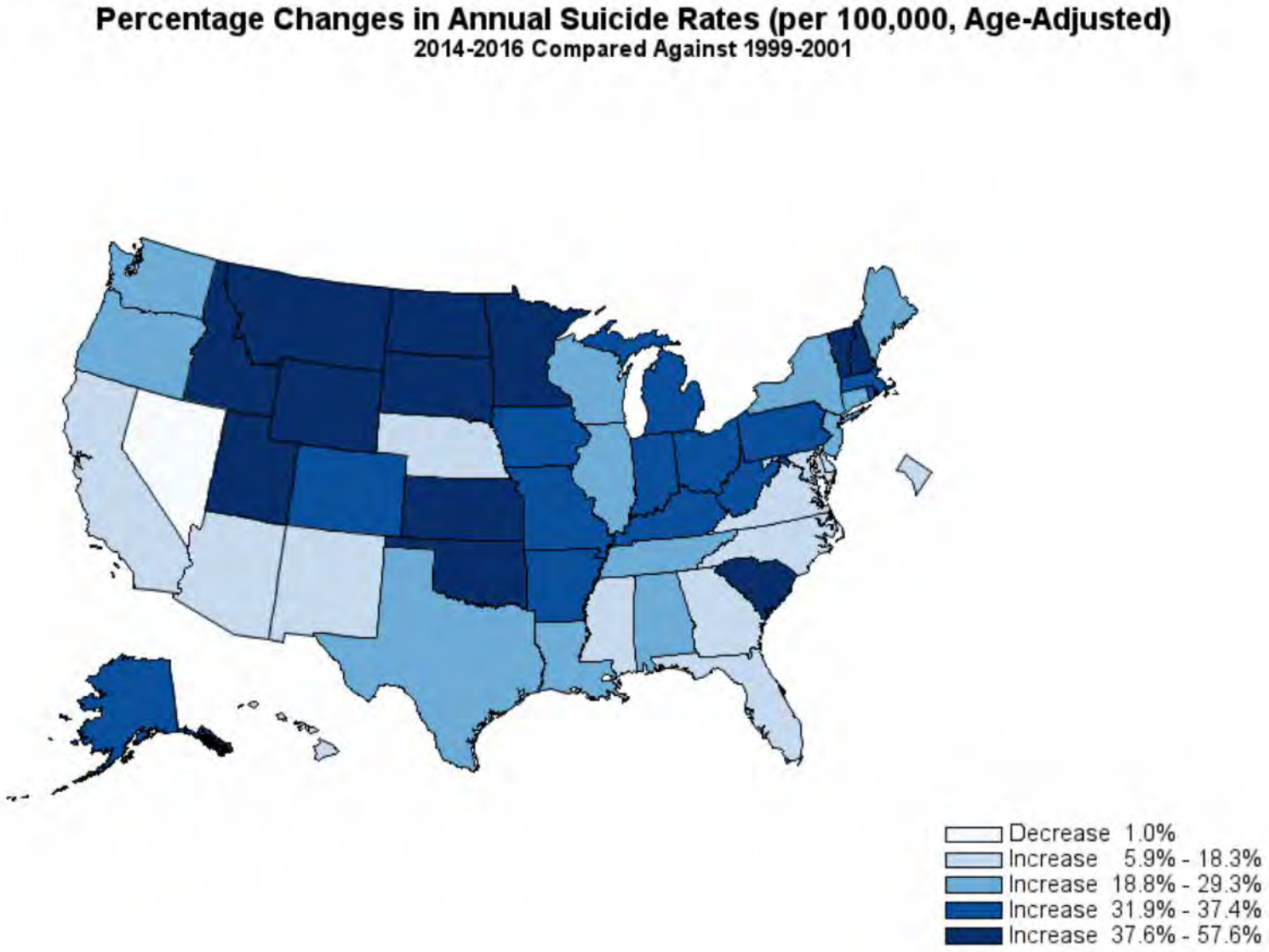
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Figure 1.


Percentage Changes in Annual Suicide Rates (per 100,000, Age-Adjusted)
2014-2016 Compared Against 1999-2001
Decrease 1.0%
Increase 5.9% - 18.3%
Increase 18.8% - 29.3%
Increase 31.9% - 37.4%
Increase 37.6% - 57.6%

Rev 3.19.18 v3

Short title: Vital Signs: Increasing Trends in State Suicide Rates and Contributing Circumstances

Deborah M. Stone, ScD;[1] Thomas R. Simon PhD;[1] Katherine A. Fowler, PhD;[1] Scott R. Kegler, PhD;[2] Keming Yuan, MS;[1] Kristin M. Holland, PhD;[1] Asha Z. Ivey-Stephenson, PhD;[1] Alex E. Crosby, MD[1]

Structured abstract (256252/250 words—this word count is not included in the 1800 max for the remainder)

Background: Overall sSuicide rates have been rising in the United States since 1999. Examining state-level trends in suicide and its multiple contributing circumstances, can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates, by state and sex, among people aged ≥10 years, were assessed using data from the National Vital Statistics System. Changes in rates were examined across six consecutive three-year periods from 1999-2016. TheCDC's National Violent Death Reporting System (2015), covering 27 states, was used to examine the precipitating circumstances among suicide decedents with and without known mental health problems (MHP).

Results: Forty-four states saw statistically significant sSuicide rates increases significantly from 1999-2016 in 44 states. In 25 states, rates increased by 30% or more. Male suicide rates increased significantly in 34 states, while fFemale rates increased significantly in 43 states. People with (46%) and without (54%) known MHP had both differing and similar circumstances precipitating suicide. Several circumstance, such as any relationship problems/loss (39.6 and 45.1%, $p \leq .01$), any life stressors/loss (49.7 and 54.2%, $p \leq .01$), and recent crises (26.0 and 32.9%, $p \leq .01$), respectively, were more likely among those without known MHP, but were common across groups.

Conclusions: Suicide rates rose significantly across most states from 1999-2016. Varied circumstances beyond MHP alone contributed to suicides among people with and without known MHP.

Implications for Public Health Practice: States can use a comprehensive public health approach based on the best available evidence to prevent suicide risks before they occur, identify and support people already at risk, prevent reattempts, and help friends/family after a suicide occurs.

INTRODUCTION

BACKGROUND AND PURPOSE (255/260 words)

In 2016, nearly 45,000 suicides (15.6/100,000) occurred in the United States (U.S.), among people ≥10 years old [1]. Between 1999 and 2016, suicide rates increased across sexes, racial/ethnic groups, and urbanization levels [2, 3]. Suicide is the 10th leading cause of death and is among the only leading causes to be *increasing* [1, 4]. Additionally, rates of Emergency Department visits for nonfatal self-harm injury, a key risk factor for suicide, increased more than 40% between 2001 and 2015 [1]. Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs [1].

The *National Strategy for Suicide Prevention(NSSP)* [5] calls for a public health approach to suicide with prevention with efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal), of the social ecology. Such an approach underscores that suicide is rarely caused by any single factor alone, but rather, is multi-determined. Despite the NSSP guidance, suicide prevention efforts largely focus on identifying and treating individuals with mental health problems (MHP) [6]. Other associated contributing risk factors include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, poor coping and problem-solving skills, and prior suicide attempts, among others [5]. Expanded

Comment [BE(]: Sometimes it is referred to as a 'contributing circumstance' and sometimes its referred to as a 'contributing factor'. I wonder if its

Comment [FC(]: Can a couple of words be added here to reflect a date since rates have been rising. I see word count is an issue and I think a couple of words can

Comment [FC(]: Style consideration. Since focus on suicide and states is clear, may not these words twice in sentence which would reduce word count. A few

Comment [FC(]: The transition from reading NVDRS covers 27 states to methods to the first line in the results referring to 44 states made me pause and

Comment [FC(]: Unclear if this was supposed to be a reference or can come out.

Comment [BE(]: I think this is a Significant finding should we say more about it the fact that it is increasing more in women?

Comment [FC(]: I think edits are needed here for a few reasons. I am finding the statements that there are differences and similarities vague and hard to follow.

Comment [FC(]: Please double check. I am getting 15.9 from WISQARS

Comment [BE(]: Can we be more specific – is it the only or is it one of only X leading causes increasing – 'among the only' is vague?

Comment [FC(]: Please double check. Wonder if this might have been calculated for all ages and not limited to ≥10 years.

Comment [BE(]: Is it better to say social ecology (which I think many think of social, environmental and economic) versus I think what is used most often the

awareness of the additional circumstances that contribute to suicide risk apart from MHP, can help reach the nation's goal of reducing suicide rates 20% by 2025 [7]. To assist states in achieving this goal, this study analyzes state-specific trends in suicide rates, assesses the multiple contributing factors ~~associated with suicide~~, and provides recommendations for multi-level comprehensive suicide prevention.

METHODS (257/260 words)

Suicide rates were analyzed for those aged 10 years and older (because of variability in attributions of suicidal intent, younger children are excluded) [8]. Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases 10th Revision* [ICD-10] underlying-cause-of death codes X60-X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive three-year aggregate periods from 1999-2016. Rate estimates were age-adjusted to the U.S. year 2000 standard population and expressed per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same three-year data aggregates, employing weighted least squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes (AAPCs).

Data from 2015 from the 27 states with complete data participating in ~~the~~CDC's National Violent Death Reporting System (NVDRS), ages 10 and older, were used to compare the characteristics among suicide decedents with and without known current ~~mental health problems~~ (MHP). MHP are defined in NVDRS as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [9], except alcohol and other substance use disorders (captured separately). NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. Decedents with and without known MHP were compared using Chi-square tests; logistic regression was used to estimate adjusted odds ratios with 95% confidence intervals (CI), controlling for age group, sex, and race/ethnicity.

RESULTS (612/591 words)

The most recent overall suicide rates (representing 2014-2016) ranged from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year, a four-fold difference (Table 1). Across the entire study period, rates increased in all but one state (Nevada), with absolute increases ranging from +0.2 (Delaware) to +8.1 (Wyoming) per 100,000. Percentage increases in rates ranged from +5.9% (Delaware) to +57.6% (North Dakota), with percentage increases of at least 30% observed in 25 states.

Modeled suicide rate trends indicated significant increases for 44 states, as well as for the U.S. overall (Table 1). By sex, modeled rate trends indicated significant increases in 34 states for males and in 43 states for females. Nationally, the model-estimated AAPC for the overall suicide rate was +1.5%. By sex, the national AAPC was +1.1% for males and +2.6% for females.

Suicide decedents with (N=9,407) and without (N=11,039) known MHP were compared. ~~While b~~Both groups were predominately male and non-Hispanic white. ~~, s~~Suicide decedents without known MHP relative to those with known MHP were more likely to be male (83.6% vs. 68.8%; p≤.01), and racial/ethnic minorities (odds ratio [OR] range: 1.2-2.1; 95% CI range [1.0-1.3] – [1.6-2.0]). ~~They~~Suicide decedents without known MHP also had significantly greater odds of perpetrating homicide-suicide (adjusted odds ratio [aOR] = 2.9, 95% CI = 2.2-3.8), of firearm suicide (aOR = 1.6, 95% CI = 1.5-1.7), and of positive toxicology results for alcohol (aOR = 1.2, 95% CI = 1.1-1.3). Fifteen percent of ~~those~~adult decedents with known MHP and 20% without ever served in the U.S. military.

Comment [BE(]: Is it really the 'nation's goal' – versus the goal set by the American Foundation for Suicide Prevention.

Comment [FC(]: I am confused by how the alcohol and substance use disorder exception is described. DSM-5 does have an alcohol use disorder diagnosis and a substance use disorder dx.

Comment [FC(]: Some labeling of the tables and how reflected in the text need some modification. There are current two "Table 1" in attachments (i.e., state trends; select demographics). The two NVDRS tables and figure 1 don't appear to be referred in the text yet.

Comment [BE(]: Per our discussion in our last VS group meeting, should we add a note that despite NV not increases, they still have a significantly high rate of suicide?

Comment [FC(]: Please double check. Table reflects +0.8

Comment [FC(]: Suggest revising in order to allow in the next sentence the comparison group to be clear and the order the %'s should be considered clearer. Tracked is an idea.

Comment [FC(]: Wonder if need to be clear here this is limited to 18+. Tracked might be a simple approach to consider.

I have seen MMWR want to present %'s to first decimal place consistently. Here is an idea of how that could be done here: *Among adult decedents 15.3% with known MHP and 20.1% without known MHP ever served in the military.*

Although firearms were used most often in both groups, decedents with known MHP died by poisoning more than those without known MHP (19.8% vs. 10.4%; $p \leq .01$), most frequently by over-the-counter/otherwise unclassified drugs (35.8%), opioids (32.7%), antidepressants (34.6%) or benzodiazepines (25.1%).

All suicide decedents with known MHP (N=9,407) and approximately 85% without (N=9,357) had precipitating circumstances information (Table 2 or 3??). People with known MHP were more likely to have any substance abuse problems (31.6% vs. 25%, $p \leq .01$). While two-thirds of those with known MHP had a history of MH or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment at the time of their deaths.

Decedents without known MHP, versus those with known MHP had a greater likelihood of any relationship problem/loss (45.1% ~~and~~vs. 39.6%, $p \leq .01$), specifically intimate partner problems (30.2% ~~and~~vs. 24.1%, $p \leq .01$), arguments/conflicts (17.5% ~~and~~vs. 13.6%, $p \leq .01$), and recently perpetrating interpersonal violence (3.0% ~~and~~vs. 1.4%, $p \leq .01$). They were also more likely to have experienced other life stressors, such as criminal-legal problems (10.7% ~~and~~vs. 6.2%, $p \leq .01$) or eviction/loss of home (4.3% ~~and~~vs. 3.4%, $p \leq .01$), and they were more likely to have had a crisis within the preceding or upcoming two weeks (32.9% ~~and~~vs. 26.0%, $p<.01$). Among both groups, the most common crises were intimate partner (35.6%) and physical health (13.4%) problems.

Decedents without known MHP had significantly lower odds of recent release from any institution, but among those who were recently released, those without a known MHP were more likely to be released from a correctional facility (25.7% vs. 8.7%, $p\leq.01$) or hospital (43.7% vs. 33.0%, $p\leq.01$) than those with a known MHP. Among decedents with known MHP recently released from an institution (10.2%), 42.8% were released from psychiatric facilities.

Suicide decedents without known MHP were more likely than those without known MHP to leave a suicide note (35.1% ~~and~~vs. 31.8%, $p \leq .01$). ~~while d~~Decedents with known MHP, compared to those without known MHP, were more likely to have a history of suicidal ideation (40.8% vs. 23.0%, $p \leq .01$) and attempts (29.4% vs. 10.3%, $p \leq .01$).

Conclusions and Comments (655/715 words)

From 1999-2016, 44 states saw significant suicide rate increases. Half of the states experienced increases of 30% or more. Rates increased significantly in 34 states among males and 43 states among females. More research into the causes of these trends is necessary [10].

One important factor associated with suicide is MHP. Nearly half of suicide decedents in NVDRS had a known MHP. This group was challenged by comorbid substance abuse problems (31.6%) and histories of suicidal ideation (40.8%) and attempts (29.4%). While two-thirds of people with known MHP had a history of MH and/or substance abuse treatment and over half were in treatment at the time of their deaths, additional support could help address the needs of this vulnerable population. This includes broader implementation of affordable and evidence-based treatments, such as doctor-patient collaborative care models and cognitive-behavioral therapy. Additionally, greater access to behavioral health providers, especially in underserved areas is important, as is healthcare systems ~~change~~ that supports suicide prevention and patient safety through care transitions [11].

While mental health problems are a significant contributor to suicide, 54% of suicide decedents in this study did *not* have a known MHP. This group suffered more relationship problems and life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises. This is noteworthy in light of findings that suggest many suicides and attempts occur with minimal deliberation time, particularly among people without mental health disorders and who faced impending life crises [12].

Comment [FC(]: I think the comparison group %'s are needed. For instance, drugs (35.8% vs. 35.8%).

I think the presentation of the %'s would be easier here and later on in the results if the p's came out and the text could simply reflect "significant differences" or some variation of indicating in the groups were different.

Comment [BE(]: Sometimes criminal-legal is hyphenated and sometimes it's not.

Comment [FC(]: The % reported in this sentence appear to be only for the group with MHPs. Based on the sentence wording, the % for both groups need to be reported.

Comment [FC(]: Please double check number. Table reflects 33.8%

Comment [FC(]: My two cents: I think we should do more to raise attention to the fact that almost a quarter of both groups disclosed suicide intent. This is a true prevention opportunity so I think this is a common risk to highlight. Knowing space constraints, I think this is more important to highlight than the presence of a suicide note which often doesn't inform prevention. I suggest adding into results and into discussion.

Comment [FC(]: I feel that MMWRs typically don't do a lot of repeat of the specific data findings in the discussion. I think the numbers could come out here. I think it would be helpful to put this into a larger context, indicating whether this is consistent with other research. I also

Comment [BE(]: I would add the percentage in parenthesis (X%).

People with known MHP also experienced other life stressors such as job and/or financial, ~~problems,~~ relationship ~~problems~~, and/or physical health problems. These findings point to the need to both prevent the conditions associated with mental health problems in the first place and the need to support people with known MHP to decrease their vulnerability to poor social, health, and economic outcomes [13].

These results underscore the importance of comprehensive statewide suicide prevention activities that go beyond a focus on ~~MH~~mental health treatment alone. Prevention strategies may include: strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills, especially early in life to manage everyday stressors and prevent future relationship problems; and promoting social connectedness to increase a sense of belongingness and access to informational, tangible, emotional, and social support~~, as needed~~. Other strategies ~~indicated by these results~~ include creating protective environments (e.g., reducing access to lethal means among people at risk, creating organizational and workplace policies to promote help-seeking and positive social norms), supporting family and friends after a suicide ~~has taken place~~, and assuring safe reporting by the media in order to prevent suicide contagion [11]. Some states, such as Colorado, are planning and implementing a comprehensive statewide approach to suicide prevention [14].

The ~~study~~ findings have at least three limitations. In the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent, or by decreased percentages of such deaths over time, which likely include some unrecognized suicides. Second, NVDRS is not yet nationally representative, and this study's. ~~This study used the most current data available which~~ data includedes 27 states that represent ~~half (~~49.6%~~)~~ of the U.S. population. Third, abstractors of NVDRS data are limited to data included in investigative reports. ~~For example, m~~Medical and ~~MH~~mental health information ~~are not captured directly from medical records but~~ come from key informants (e.g., family, friends) via coroner/medical examiner reports and can . ~~Therefore, informant knowledge~~ impacts ~~the~~data completeness and accuracy. ~~of the information reported, and~~ Some studies including in-depth interviews with family members show ~~often see~~ greater attributions to ~~MH~~mental health and substance abuse disorders than medical records, ~~however methodological variation across studies exists~~ [15]. It is likely that some people without known MHP in the current study were experiencing mental health challenges at the time of death that were either not known or reported by informants. ~~or were not captured in NVDRS's primary data sources. The lack of awareness of a mental health problem suggests the importance of addressing the range of contributing circumstances~~.

Suicide is a growing public health problem. Mental illness is an important risk factor for suicide, and is one of many requiring preventive action. Data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices* [11] can help states and communities better understand their suicide problem and prioritize comprehensive suicide prevention.

Acknowledgments
The authors acknowledge Robert Anderson, Holly Hedegaard, and Margaret Warner from the Division of Vital Statistics, National Center for Health Statistics, CDC, for their statistical consultation.

Conflict of Interest No conflicts of interest were reported.

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Author Affiliations:

Comment [FC(]: I suggest pulling this out into a separate paragraph. If contained in the above, it seems to undercut the main point that many suicides don't have MPH. A new paragraph might need a lead-in sentence or maybe start with the current last sentence to frame points about common risks.

Comment [BE(]: Should this be 'and', 'or' or 'and/or'?

Comment [FC(]: I think it is fine that the TP strategies are presented in different areas of the discussion. I don't easily see "identify and support people at-risk". I think that can go in the proposed paragraph immediately above when talking about common risk factors. In adding that, suggest adding some examples of approaches (e.g., crisis intervention, gatekeeper training).

Comment [FC(]: I am not easily following this point. Can this be stated more simply such as "…impacted by variations of undetermined injury deaths, which likely….

To help w/word count, offer a couple of suggestions in next few sentences to streamline. Certainly take/leave what you like and check for accuracy.

Comment [BE(]: Do you mean 'NOT' reported by informants?

Comment [FC(]: To me, this sentence puts the spotlight back on mental illness and makes it likely it will be the take home message of media reporting. If that isn't the goal of this VS, suggest framing broadly. Ideas: *Effective approaches are available to prevent or ameliorate many suicide risk factors, such as depression and anxiety, recent crisis, substance use, intimate partner problems, and financial problems.* –OR—*No one factor causes suicide so preventive action must address multiple factors, such as XX*

[1]Division of Violence Prevention, National Center for Injury Prevention and Control, CDC; [2]Division of Analysis, Research, and Practice Integration, National Center for Injury Prevention and Control, CDC

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Tables and Figures (attachments)

Table 1 and Figure 1.doc

Tables 2 and 3.pdf

Word Count: 1826/1800

DRAFT

From: Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Sent: 22 Mar 2018 14:25:03 -0400
To: Mercy, James (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR
Attachments: MMWR Table 1 and Figure 1_CF.docx, Copy of Tables (23) Suicide Vital Signs NVDRS_031918 (pre-clearance)_CF.xlsx, Suicide Vital Signs MMWR Text 3.19.18 v3 (pre-clearance)_CF.docx

Deb,
Congratulations to you and the entire vital signs writing team to getting to this point! It is an enormous achievement. I really like the direction the analyses have gone in. I know there is a considerable amount of work ahead, but you have a solid platform to build on.
I offer in the attachments some suggestions. Track changes are not easily done in the excel file so I highlight words in red to draw your attention to things to consider. In the text, I think there are a few numbers to double check, a few data points and clarifications to be added in, and the references to the tables/figure adjusted. I do like the balance that is currently in there on the %'s versus aORs.
Mental health problems as a driver of suicide jumped out to me as one of the main messages since the text kept coming back to it. I think there are some subtle reorganization or broader phrasing that could be used in some places to modify this if the communication goal is different; I offer some ideas in comment boxes. I recognize that I am suggesting adding some clarifying text in some places and word count is always an issue, so I did try to identify some places to potentially cut. Please review this as suggestions and take/leave what feels right.
FYI, in a meeting I was in with the MMWR editors yesterday they said they prefer little to no use of acronyms. So, in a few places I suggest taking a couple out but I did leave in the MHP one since that is necessary for word count.
Cory

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 12:34 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Ferdon, Corinne (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Pre-clearance Draft of Suicide Vital Signs MMWR

Hi Deb,
This is outstanding. Thank you and everyone else for this really nice and clear statement about suicide and its prevention. I have just a few general comments/suggestions:

1. One finding that you don't make much of, but I think is important, is that suicide rates across states are increasing faster for females relative to males. Overall, of course, this is a problem still dominated by males, but that appears to be changing. And that's not surprising in terms of societal changes around gender roles and norms. I realize you can't highlight everything, but that is very interesting and may signal a longer term trend that's worth noting.
2. You may have to cut back the word number some and if you do I think you can get away without the second sentence in the results that focusses on absolute changes in rates. People understand the meaning of % changes much easier, so no biggie, but that could be dropped if needed.
3. In regards to the first sentence in the last paragraph, I wondering if the last clause could be changed to "…, but is only one of several…" If we say one of "many" then the argument is that

we can't focus on everything so we should focus on the most important risk factor. I'm not wedded to this, but clearly we are emphasizing the need to focus on factors beyond mental illness (but not excluding mental illness) and I think this sentence could be made a little stronger in support of that, especially because it ties things up at the end.

Thanks that is all I had. Thanks so much and can't wait until this comes out.

Jim

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 22, 2018 8:14 AM
To: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: Pre-clearance Draft of Suicide Vital Signs MMWR
Importance: High

Hi Jim, Cory, Erin, and Malia,

Just a friendly reminder to please send your feedback on the MMWR by COB today. Your time and insights are greatly appreciated!

Deb

*****

Hi Everyone,

Please find attached a draft of our suicide Vital Signs MMWR for pre-clearance.

Thank you for previously agreeing to review it with a quick turnaround of COB 3/22.

We are still working out one outstanding issue—whether to report percentages and/or aORs pertaining to NVDRS results.

Right now we opt for percentages however we may also include aOR and CI's.

Please send your edits in tracked changes. If you have any questions, please let me know.

We look forward to your feedback! And thanks to the whole team for a whole lot of time, thought, and expertise dedicated to this draft!

Thanks again!

Deb

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Through Science and Action

Table 1. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Differences between ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

Comment [FC(]: Wonder if in a revised title or footnote if it needs to be revised to reflect this also includes District of Columbia.

Comment [FC(]: Suggest being clear on what these period, similar to how done in another footnote.

Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

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Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

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Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

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		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

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Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30)	+ 34.1 % (23)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3)	+ 46.5 % (4)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Differences between ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first and last periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Differences between ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Differences between ranks do not necessarily imply a statistically significant difference.

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†† Rate based on < 20 suicides.

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¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

Figure 1.

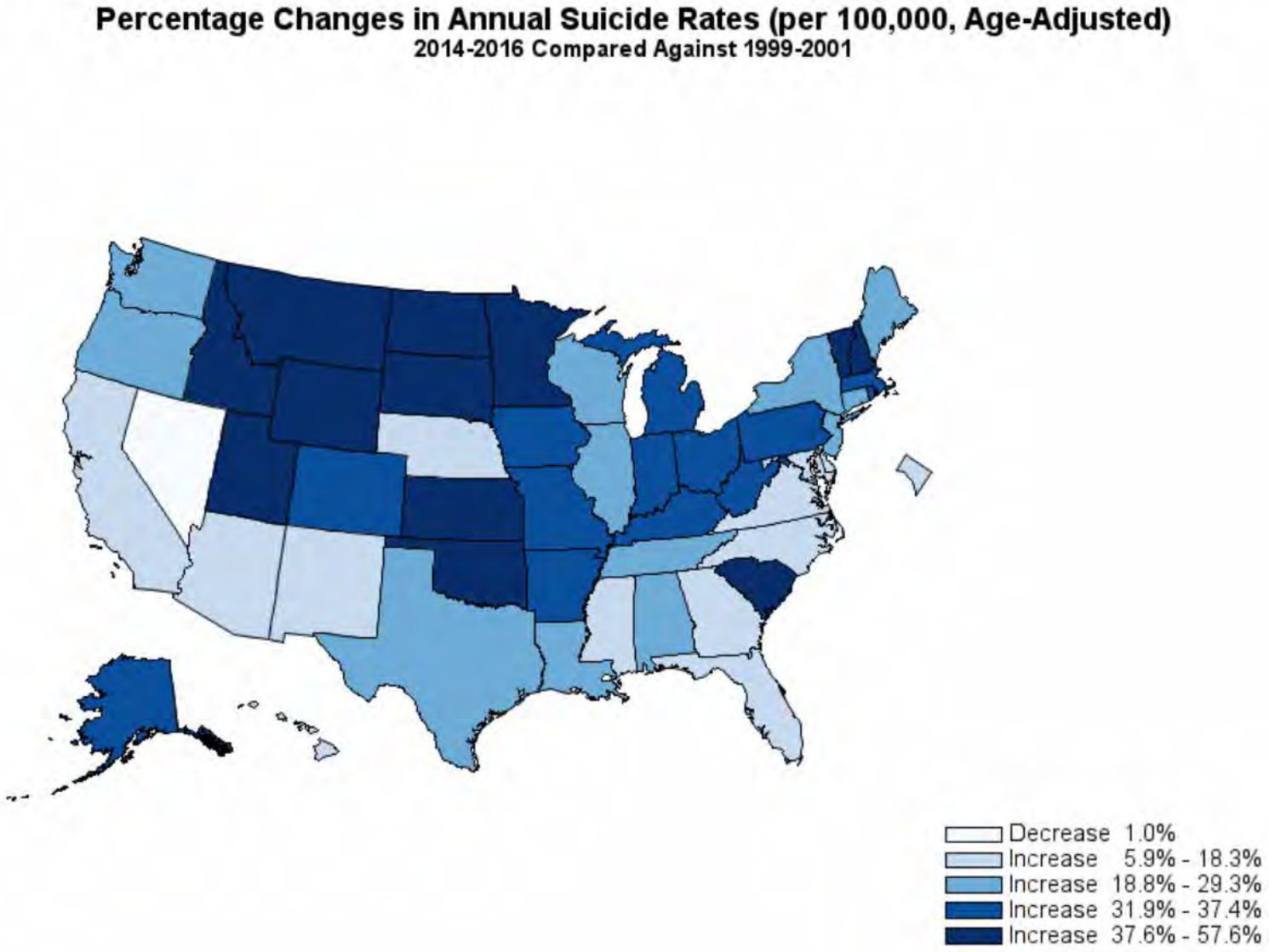

Percentage Changes in Annual Suicide Rates (per 100,000, Age-Adjusted)
2014-2016 Compared Against 1999-2001
Decrease 1.0%
Increase 5.9% - 18.3%
Increase 18.8% - 29.3%
Increase 31.9% - 37.4%
Increase 37.6% - 57.6%

Table 1. Select Demographic and Descriptive Characteristics of Suicides among Decedents >10 years of age with and without Known Mental Health Problems--National Violent Death Reporting System, 27 states*, 2015

Characteristics	Total (n=20,446)	Known Mental Health Problem† (n=9,407)	No Known Mental Health Problem (n=11,039)	Chi-Square	OR (95% CI)	Adjusted OR§ (95% CI)
Sex						
Male	15,702(76.8)	6,469(68.8)	9,233(83.6)	p<.01	2.3(2.2-2.5)	
Female	4,744(23.2)	2,938(31.2)	1,806(16.4)	p<.01	0.4(0.4-0.5)	
Age¶						
10-24	2,804(13.7)	1,211(12.9)	1,593(14.4)	p<.01	1.1(1.1-1.2)	
25-44	6,456(31.6)	3,036(32.3)	3,420(31.0)	p<.05	0.9(0.9-1.0)	
45-64	7,718(37.7)	3,820(40.6)	3,898(35.3)	p<.01	0.8(0.8-0.8)	
65+	3,468(17.0)	1,340(14.2)	2,128(19.3)	p<.01	1.4(1.3-1.5)	
Race/ethnicity						
White, non-Hispanic	17,102(83.6)	8,165(86.8)	8,937(81.0)	p<.01	0.6(0.6-0.7)	
Black, non-Hispanic	1,228(6.0)	411(4.4)	817(7.4)	p<.01	1.7(1.5-2.0)	
American Indian/Alaska Native, non-Hispa	378(1.8)	112(1.2)	266(2.4)	p<.01	2.0(1.6-2.6)	
Asian, non-Hispanic	576(2.8)	235(2.5)	341(3.1)	p<.05	1.2(1.1-1.5)	
Hispanic	1,096(5.4)	463(4.9)	633(5.7)	p<.05	1.2(1.0-1.3)	
Other	66(0.3)	21(0.2)	45(0.4)	p<.05	1.8(1.1-3.1)	
Extended demographics						
Ever served in military**	3,429(17.8)	1,354(15.3)	2,075(20.1)	p<.01	1.4(1.3-1.5)	1.1(1.0-1.1)
Homeless	240(1.2)	104(1.1)	136(1.3)		1.1(0.9-1.5)	1.2(0.9-1.5)
Incident Type						
Homicide followed by suicide	319(1.6)	64(0.7)	255(2.3)	p<.01	3.5(2.6-4.5)	2.9(2.2-3.8)
Single suicide	20,063(98.2)	9,318(99.1)	10,745(97.4)	p<.01	0.3(0.3-0.4)	0.4(0.3-0.5)
Method						
Firearm	9,909(48.5)	3,821(40.6)	6,088(55.3)	p<.01	1.8(1.7-1.9)	1.6(1.5-1.7)
Hanging/Strangulation/Suffocation	5,907(28.9)	2,940(31.3)	2,967(26.9)	p<.01	0.8(0.8-0.9)	0.8(0.7-0.8)
Poisoning	3,003(14.7)	1,861(19.8)	1,142(10.4)	p<.01	0.5(0.4-0.5)	0.6(0.6-0.7)
Substance class causing death††						
Other (e.g., over-the-counter)	1,021(34.0)	666(35.8)	355(31.1)	p<.01	0.8(0.7-0.9)	0.9(0.7-1.0)
Opioids	944(31.4)	608(32.7)	336(29.4)		0.9(0.7-1.0)	0.9(0.8-1.1)
Antidepressants	800(26.6)	644(34.6)	156(13.7)	p<.01	0.3(0.2-0.4)	0.3(0.3-0.4)
Benzodiazepines	624(20.8)	468(25.1)	156(13.7)	p<.01	0.5(0.4-0.6)	0.5(0.4-0.6)
Antipsychotics	219(7.3)	195(10.5)	24(2.1)	p<.01	0.2(0.1-0.3)	0.2(0.1-0.3)
Other	1,595(7.8)	780(8.3)	815(7.4)	p<.05	0.9(0.8-1.0)	0.9(0.8-1.0)
Toxicology Results						
Any toxicology testing	13,317(65.1)	6,658(70.8)	6,659(60.3)	p<.01	0.6(0.6-0.7)	0.7(0.6-0.7)
Positive for ≥ 1 substance§§	9,913(74.4)	5,192(78.0)	4,721(70.9)	p<.01	0.7(0.6-0.7)	0.8(0.7-0.8)
Substance detected***						
Alcohol						
Tested	10,950(53.6)	5,409(57.5)	5,541(50.2)	p<.01	0.7(0.7-0.8)	0.8(0.7-0.8)
Positive	4,442(40.6)	2,115(39.1)	2,327(42.0)	p<.01	1.1(1.0-1.2)	1.2(1.1-1.3)
Opioids						
Tested	8,554(41.8)	4,258(45.3)	4,296(38.9)	p<.01	0.8(0.7-0.8)	0.8(0.8-0.9)
Positive	2,279(26.6)	1,238(29.1)	1,041(24.2)	p<.01	0.8(0.7-0.9)	0.9(0.8-1.0)
Benzodiazepines						
Tested	8,124(39.7)	4,226(44.9)	3,898(35.3)	p<.01	0.7(0.6-0.7)	0.7(0.7-0.8)
Positive	2,464(30.3)	1,639(38.8)	825(21.2)	p<.01	0.4(0.4-0.5)	0.5(0.5-0.6)
Cocaine						
Tested	7,978(39.0)	3,866(41.1)	4,112(37.2)	p<.01	0.9(0.8-0.9)	0.9(0.9-1.0)
Positive	499(6.3)	216(5.6)	283(6.9)	p<.05	1.2(1.0-1.5)	1.2(1.0-1.5)
Amphetamines						
Tested	7,615(37.2)	3,696(39.3)	3,919(35.5)	p<.01	0.9(0.8-0.9)	0.9(0.8-0.9)
Positive	736(9.7)	376(10.2)	360(9.2)		0.9(0.8-1.0)	1.0(0.8-1.1)
Marijuana						
Tested	6,569(32.1)	3,127(33.2)	3,442(31.2)	p<.01	0.9(0.9-1.0)	0.9(0.9-1.0)
Positive	1,471(22.4)	710(22.7)	761(22.1)		1.0(0.9-1.1)	0.9(0.8-1.0)
Antidepressants						
Tested	5,425(26.5)	3,103(33.0)	2,322(21.0)	p<.01	0.5(0.5-0.6)	0.6(0.6-0.7)
Positive	2,214(40.8)	1,735(55.9)	479(20.6)	p<.01	0.2(0.2-0.2)	0.2(0.2-0.3)

* Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey,

† Decedent had been identified as currently having a diagnosed mental health problem in coroner/medical examiner or law enforcement reports.

§ Logistic regression was used to estimate adjusted odds ratio with 95% CIs after controlling for age, sex, race and ethnicity.

¶ Decedents were aged 10 years and older, as per standard in the suicide prevention literature.

** Denominator is decedents aged 18 years of age and older with reported military service status.

†† Denominator is decedents who died by poisoning, including overdose.

§§ Denominator is decedents with any toxicology tested.

*** Denominator for each positive group is the number tested for the substance in that group.

is an additional footnote needed on total or on the categories below to reflect why some don't add up to the overall total (e.g., age, incident type)

"single suicide" made me wonder about simultaneous or related suicides (ie more than one person), especially given this is available in NVDRS. Wonder if need another category for murder/related suicides or if the suicide suicide category should be renamed.

Considerable on both excel tables. "Currently having" feels odd to me since the individual is deceased. Could modify to something "having a current diagnosed mental health problem at time of death..."
Also think on both table examples or how MHP is defined is needed in the footnote to help the tables be interpretable independently from text

Table 2. Circumstances Preceding Suicide among Decedents ≥10 years of age with and without Known Mental Health Problems--National Violent Death Reporting System, 27 states*, 2015

Characteristics	Total	Known Mental Health Problem†	No Known MH Problem	Chi-Square	OR (95% CI)	Adjusted OR§ (95% CI)
Suicide with known circumstances	18,764(91.8)	9,407(100)	9,357(84.8)	p<.01		
Mental Health/Substance Problems						
Any Current Mental Health Diagnosis¶						
Depression/dysthymia	7,076(75.2)	7,076(75.2)				
Anxiety disorder	1,579(16.8)	1,579(16.8)				
Bipolar disorder	1,431(15.2)	1,431(15.2)				
Schizophrenia	509(5.4)	509(5.4)				
PTSD	424(4.5)	424(4.5)				
ADD/ADHD	226(2.4)	226(2.4)				
Unknown	760(8.1)	760(8.1)				
Current depressed mood	7,038(37.5)	3,962(42.1)	3,076(32.9)	p<.01	0.7(0.6-0.7)	0.7(0.6-0.7)
Substance Problems						
Any Current substance problem	5,319(28.3)	2,976(31.6)	2,343(25.0)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Alcohol problem	3,268(17.4)	1,862(19.8)	1,406(15.0)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Other substance problem	3,084(16.4)	1,768(18.8)	1,316(14.1)	p<.01	0.7(0.7-0.8)	0.7(0.7-0.8)
Treatment						
Current mental health/substance abuse treatment	5,141(27.4)	5,077(54.0)	64(0.7)	p<.01	0.0(0.0-0.0)	0.0(0.0-0.0)
Ever treated for metnal health/substance problem	6,717(35.8)	6,323(67.2)	394(4.2)	p<.01	0.0(0.0-0.0)	0.0(0.0-0.0)
Relationship Problems/Loss						
Any relationship problem/loss	7,948(42.4)	3,726(39.6)	4,222(45.1)	p<.01	1.3(1.2-1.3)	1.3(1.2-1.4)
Intimate partner problem	5,098(27.2)	2,270(24.1)	2,828(30.2)	p<.01	1.4(1.3-1.5)	1.4(1.3-1.5)
Perpetrator of interpersonal violence past month	414(2.2)	131(1.4)	283(3.0)	p<.01	2.2(1.8-2.7)	2.0(1.6-2.4)
Victim of interpersonal violence within past month	84(0.4)	53(0.6)	31(0.3)	p<.05	0.6(0.4-0.9)	0.8(0.5-1.2)
Family relationship problem	1,671(8.9)	873(9.3)	798(8.5)		0.9(0.8-1.0)	1.0(0.9-1.1)
Other relationship problem (non-intimate)	403(2.1)	202(2.1)	201(2.1)		1.0(0.8-1.2)	1.1(0.9-1.3)
Argument or conflict (not specified)	2,914(15.5)	1,278(13.6)	1,636(17.5)	p<.01	1.3(1.2-1.5)	1.4(1.3-1.5)
Death of a loved one (any)	1,497(8.0)	826(8.8)	671(7.2)	p<.01	0.8(0.7-0.9)	0.9(0.8-0.9)
Non-suicide death	1,181(6.3)	647(6.9)	534(5.7)	p<.01	0.8(0.7-0.9)	0.9(0.8-1.0)
Suicide of family or friend	379(2.0)	217(2.3)	162(1.7)	p<.01	0.7(0.6-0.9)	0.8(0.7-1.0)
Other Life Stressors/Loss						
Any life stressors/loss	9,743(51.9)	4,675(49.7)	5,068(54.2)	p<.01	1.2(1.1-1.3)	1.1(1.1-1.2)
Recent criminal legal problem	1,588(8.5)	586(6.2)	1,002(10.7)	p<.01	1.8(1.6-2.0)	1.7(1.5-1.9)
Other legal problem	748(4.0)	378(4.0)	370(4.0)		1.0(0.8-1.1)	1.0(0.9-1.2)
Physical health problem	4,179(22.3)	2,012(21.4)	2,167(23.2)	p<.01	1.1(1.0-1.2)	1.0(1.0-1.1)
Job/Financial problem**	2941(16.2)	1530(16.8)	1411(15.6)	p<.05	0.9(0.8-1.0)	0.9(0.8-1.0)
Eviction or loss of home	722(3.8)	317(3.4)	405(4.3)	p<.01	1.3(1.1-1.5)	1.4(1.2-1.6)
School problem††	162(19.9)	70(17.8)	92(21.9)		1.3(0.9-1.8)	1.3(0.9-1.9)
Recent release from an institution§§	1,412(7.6)	941(10.2)	471(5.1)	p<.01	0.5(0.4-0.5)	0.5(0.4-0.5)
Jail/prison/detention facility	203(14.4)	82(8.7)	121(25.7)	p<.01	3.6(2.7-4.9)	4.5(3.2-6.4)
Hospital	517(36.6)	311(33.0)	206(43.7)	p<.01	1.6(1.3-2.0)	1.3(1.0-1.7)
Psychiatric hospital	432(30.6)	403(42.8)	29(6.2)	p<.01	0.1(0.1-0.1)	0.1(0.1-0.1)
Other psychiatric institution	37(2.6)	36(3.8)	1(0.2)	p<.01	0.1(0.0-0.4)	—¶¶
Residential facility (alc/SA treat)	80(5.7)	50(5.3)	30(6.4)		1.2(0.8-1.9)	—¶¶
Other	143(10.1)	59(6.3)	84(17.8)	p<.01	3.2(2.3-4.6)	3.1(2.2-4.5)
Crisis within past or upcoming two weeks***	5,525(29.4)	2,444(26.0)	3,081(32.9)	p<.01	1.4(1.3-1.5)	1.4(1.3-1.5)
Intimate partner problem crisis	1968(35.6)	854(34.9)	1114(36.2)		1.1(0.9-1.2)	1.1(0.9-1.2)
Physical health problem crisis	739(13.4)	315(12.9)	424(13.8)		1.1(0.9-1.3)	1.0(0.8-1.2)
Criminal legal problem crisis	621(11.2)	203(8.3)	418(13.6)	p<.01	1.7(1.5-2.1)	1.6(1.3-1.9)
Family relationship problem crisis	430(7.8)	212(8.7)	218(7.1)	p<.05	0.8(0.7-1.0)	0.9(0.7-1.1)
Job problem crisis	354(6.4)	191(7.8)	163(5.3)	p<.01	0.7(0.5-0.8)	0.7(0.5-0.8)
Suicide Event/History						
Left a note	6,468(34.5)	3,182(33.8)	3,286(35.1)		1.1(1.0-1.1)	1.2(1.1-1.2)
Disclosed suicide intent	4,405(23.5)	2,306(24.5)	2,099(22.4)	p<.01	0.9(0.8-1.0)	0.9(0.8-0.9)
History of ideation	5,990(31.9)	3,838(40.8)	2,152(23.0)	p<.01	0.4(0.4-0.5)	0.4(0.4-0.5)
History of attempts	3,732(19.9)	2,770(29.4)	962(10.3)	p<.01	0.3(0.3-0.3)	0.3(0.3-0.3)

*Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

† Decedent had been identified as currently having a diagnosed mental health problem in coroner/medical examiner or law enforcement reports.

‡ Logistic regression was used to estimate adjusted odds ratio with 95% CIs after controlling for age, gender, race and ethnicity.

§ Includes decedents with one or more diagnosed current mental health problems, which are not mutually exclusive. Therefore sums of percentages for the diagnosed conditions exceed 100%. Denominator includes the number of decedents with one or more current diagnosed mental health problems.

**Denominator is decedents aged 18 years of age and older.

†† Denominator is decedents aged 10-18 years.

§§ Denominator of institution subgroup is decedents with recent realease from an institution.

¶¶ Results are not reported. Model failed to converge due to data separation.

***Denominator of crisis subgroup is decedents with any crisis within past or upcoming two weeks. Crises depicted here represent the most commonly occurring categories.

Typo in "release". Is is possible to also describe what recent means? Past two week or is this quite variable? Given the broad audience of MMWR, can this be put into more simple terms?

Rev 3.19.18 v3

Short title: Vital Signs: Increasing Trends in State Suicide Rates and Contributing Circumstances

Deborah M. Stone, ScD;[1] Thomas R. Simon PhD;[1] Katherine A. Fowler, PhD;[1] Scott R. Kegler, PhD;[2] Keming Yuan, MS;[1] Kristin M. Holland, PhD;[1] Asha Z. Ivey-Stephenson, PhD;[1] Alex E. Crosby, MD[1]

Structured abstract (256/250 words—this word count is not included in the 1800 max for the remainder)

Background: ~~Overall s~~Suicide rates have been rising in the United States since 1999. Examining state-level trends in suicide and its multiple contributing circumstances~~,~~ can inform comprehensive ~~state suicide~~ prevention planning.

Methods: Trends in age-adjusted suicide rates, by state and sex, among people aged ≥10 years, were assessed using data from the National Vital Statistics System. Changes in rates were examined across six consecutive three-year periods from 1999-2016. ~~The~~CDC's National Violent Death Reporting System ~~(2015)~~, covering 27 states, was used to examine ~~the~~ precipitating circumstances among suicide decedents with and without known mental health problems (MHP).

Results: ~~Forty-four states saw statistically significant s~~Suicide rates increases significantly from 1999-2016 in 44 states. In 25 states, rates increased by 30% or more. Male suicide rates increased significantly in 34 states. ~~while f~~Female rates increased significantly in 43 states. People with (46%) and without (54%) known MHP had both differing and similar circumstances precipitating suicide. Several circumstance, such as any relationship problems/loss (39.6 and 45.1%, $p \leq .01$), any life stressors/loss (49.7 and 54.2%, $p \leq .01$), and recent crises (26.0 and 32.9%, $p \leq .01$), respectively, were more likely among those without known MHP, but were common across groups.

Conclusions: Suicide rates rose significantly across most states from 1999-2016. Varied circumstances beyond MHP alone contributed to suicides among people with and without known MHP.

Implications for Public Health Practice: States can use a comprehensive public health approach based on the best available evidence to prevent suicide risks before they occur, identify and support people already at risk, prevent reattempts, and help friends/family after a suicide occurs.

INTRODUCTION

BACKGROUND AND PURPOSE (260 words)

In 2016, nearly 45,000 suicides (15.6/100,000) occurred in the United States (U.S.), among people ≥10 years old [1]. Between 1999 and 2016, suicide rates increased across sexes, racial/ethnic groups, and urbanization levels [2, 3]. Suicide is the 10th leading cause of death and is among the only leading causes to be *increasing* [1, 4]. Additionally, rates of Emergency Department visits for nonfatal self-harm injury, a key risk factor for suicide, increased more than 40% between 2001 and 2015 [1]. Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs [1].

The *National Strategy for Suicide Prevention(NSSP)* [5] calls for a public health approach to suicide with prevention efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal), of the social ecology. Such an approach underscores that suicide is rarely caused by any single factor alone, but rather, is multi-determined. Despite the NSSP guidance, suicide prevention efforts largely focus on identifying and treating individuals with mental health problems (MHP) [6]. Other associated risk factors include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, poor coping and problem-solving skills, and prior suicide attempts~~, among others~~ [5]. Expanded awareness of the

Comment [FC(]: Can a couple of words be added here to reflect a date since rates have been rising. I see word count is an issue and I think a couple of words can come out in other places to help. Two other ideas that might help with word count in this first line:
-Suicide rates in the United State are rising.
-Suicide rates in the Unites states have risen in the United States since 1999.

Comment [FC(]: Style consideration. Since focus on suicide and states is clear, may not these words twice in sentence which would reduce word count. A few other tracked suggestion are to help reduce word count. Please take/leave what feels right.

Comment [FC(]: The transition from reading NVDRS covers 27 states to methods to the first line in the results referring to 44 states made me pause and have to go back to the methods. Feel like in this sentence it might need to be clear vital stat data is for all states plus it appears District of Columbia was a part of the analyses. Same comment applies to later detailed methods.

Comment [FC(]: Unclear if this was supposed to be a reference or can come out.

Comment [FC(]: I think edits are needed here for a few reasons. I am finding the statements that there are differences and similarities vague and hard to follow. Reporting the without MHP groups as 54% is a problem because this is correct for understanding demographics but not

Comment [FC(]: Please double check. I am getting 15.9 from WISQARS

Comment [FC(]: Please double check. Wonder if this might have been calculated for all ages and not limited to ≥10 years.

additional circumstances that contribute to suicide risk apart from MHP, can help reach the nation's goal of reducing suicide rates 20% by 2025 [7]. To assist states in achieving this goal, this study analyzes state-specific trends in suicide rates, assesses the multiple factors associated with suicide, and provides recommendations for multi-level comprehensive suicide prevention.

METHODS (260 words)

Suicide rates were analyzed for those aged 10 years and older (because of variability in attributions of suicidal intent, younger children are excluded) [8]. Age-specific suicide counts were tabulated based on National Vital Statistics System coded death certificate records (*International Classification of Diseases 10th Revision* [ICD-10] underlying-cause-of death codes X60-X84, Y87.0, U03). Age-specific population estimates were obtained from U.S. Census Bureau/National Center for Health Statistics bridged-race population data releases.

National and state-level suicide rate estimates were calculated for six consecutive three-year aggregate periods from 1999-2016. Rate estimates were age-adjusted to the U.S. year 2000 standard population and expressed per 100,000 persons per year. Age-adjusted suicide rate trends were modeled using the same three-year data aggregates, employing weighted least squares regression with inverse-variance weighting. Modeled rate trends are reported in terms of average annual percentage changes (AAPCs).

Data from 2015 from the 27 states with complete data participating in ~~the~~CDC's National Violent Death Reporting System (NVDRS), ages 10 and older, were used to compare the characteristics among suicide decedents with and without known current ~~mental health problems (~~MHP~~)~~. MHP are defined in NVDRS as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [9], except alcohol and other substance use disorders (captured separately). NVDRS aggregates data from three primary data sources: death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. Decedents with and without known MHP were compared using Chi-square tests; logistic regression was used to estimate adjusted odds ratios with 95% confidence intervals (CI), controlling for age group, sex, and race/ethnicity.

RESULTS (591 words)

The most recent overall suicide rates (representing 2014-2016) ranged from 6.9 (District of Columbia) to 29.2 (Montana) per 100,000 persons per year, a four-fold difference (Table 1). Across the entire study period, rates increased in all but one state (Nevada), with absolute increases ranging from ~~+~~0.2 (Delaware) to +8.1 (Wyoming) per 100,000. Percentage increases in rates ranged from +5.9% (Delaware) to +57.6% (North Dakota), with percentage increases of at least 30% observed in 25 states.

Modeled suicide rate trends indicated significant increases for 44 states, as well as for the U.S. overall (Table 1). By sex, modeled rate trends indicated significant increases in 34 states for males and in 43 states for females. Nationally, the model-estimated AAPC for the overall suicide rate was +1.5%. By sex, the national AAPC was +1.1% for males and +2.6% for females.

Suicide decedents with (N=9,407) and without (N=11,039) known MHP were compared. ~~While b~~Both groups were predominately male and non-Hispanic white. ~~, s~~Suicide decedents without known MHP relative to those with MHP were more likely to be male (83.6% vs. 68.8%; p≤.01), and racial/ethnic minorities (odds ratio [OR] range: 1.2-2.1; 95% CI range [1.0-1.3] – [1.6-2.0]). ~~They~~Suicide decedents without known MHP also had significantly greater odds of perpetrating homicide-suicide (adjusted odds ratio [aOR] = 2.9, 95% CI = 2.2-3.8), of firearm suicide (aOR = 1.6, 95% CI = 1.5-1.7), and of positive toxicology results for alcohol (aOR = 1.2, 95% CI = 1.1-1.3). Fifteen percent of ~~those~~adult decedents with known MHP and 20% without ever served in the U.S. military.

Comment [FC(]: I am confused by how the alcohol and substance use disorder exception is described. DSM-5 does have an alcohol use disorder diagnosis and a substance use disorder dx.

Comment [FC(]: Some labeling of the tables and how reflected in the text need some modification. There are current two "Table 1" in attachments (i.e., state trends; select demographics). The two NVDRS tables and figure 1 don't appear to be referred in the text yet.

Comment [FC(]: Please double check. Table reflects +0.8

Comment [FC(]: Suggest revising in order to allow in the next sentence the comparison group to be clear and the order the %'s should be considered clearer. Tracked is an idea.

Comment [FC(]: Wonder if need to be clear here this is limited to 18+. Tracked might be a simple approach to consider.

I have seen MMWR want to present %'s to first decimal place consistently. Here is an idea of how that could be done here: *Among adult decedents 15.3% with known MHP and 20.1% without known MHP ever served in the military.*

Although firearms were used most often in both groups, decedents with known MHP died by poisoning more than those without MHP (19.8% vs. 10.4%; $p \leq .01$), most frequently by over-the-counter/otherwise unclassified drugs (35.8%), opioids (32.7%), antidepressants (34.6%) or benzodiazepines (25.1%).

All suicide decedents with known MHP (N=9,407) and approximately 85% without (N=9,357) had precipitating circumstances information (Table 2 or 3??). People with MHP were more likely to have any substance abuse problems (31.6% vs. 25%, $p \leq .01$). While two-thirds of those with known MHP had a history of MH or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment at the time of their deaths.

Decedents without known MHP, versus those with MHP had a greater likelihood of any relationship problem/loss (45.1% ~~and~~vs. 39.6%, $p \leq .01$), specifically intimate partner problems (30.2% ~~and~~vs. 24.1%, $p \leq .01$), arguments/conflicts (17.5% ~~and~~vs. 13.6%, $p \leq .01$), and recently perpetrating interpersonal violence (3.0% ~~and~~vs. 1.4%, $p \leq .01$). They were also more likely to have experienced other life stressors, such as criminal legal problems (10.7% ~~and~~vs. 6.2%, $p \leq .01$) or eviction/loss of home (4.3% ~~and~~vs. 3.4%, $p \leq .01$), and they were more likely to have had a crisis within the preceding or upcoming two weeks (32.9% ~~and~~vs. 26.0%, $p<.01$). Among both groups, the most common crises were intimate partner (35.6%) and physical health (13.4%) problems.

Decedents without known MHP had significantly lower odds of recent release from any institution, but among those who were recently released, those without a known MHP were more likely to be released from a correctional facility (25.7% vs. 8.7%, $p\leq.01$) or hospital (43.7% vs. 33.0%, $p\leq.01$) than those with a known MHP. Among decedents with known MHP recently released from an institution (10.2%), 42.8% were released from psychiatric facilities.

Suicide decedents without known MHP were more likely than those without MHP to leave a suicide note (35.1% ~~and~~vs. 31.8%, $p \leq .01$). ~~while d~~Decedents with known MHP, compared to those without MHP, were more likely to have a history of suicidal ideation (40.8% vs. 23.0%, $p \leq .01$) and attempts (29.4% vs. 10.3%, $p \leq .01$).

Conclusions and Comments (715 words)

From 1999-2016, 44 states saw significant suicide rate increases. Half of the states experienced increases of 30% or more. Rates increased significantly in 34 states among males and 43 states among females. More research into the causes of these trends is necessary [10].

One important factor associated with suicide is MHP. Nearly half of suicide decedents in NVDRS had a known MHP. This group was challenged by comorbid substance abuse problems (31.6%) and histories of suicidal ideation (40.8%) and attempts (29.4%). While two-thirds of people with MHP had a history of MH and/or substance abuse treatment and over half were in treatment at the time of their deaths, additional support could help address the needs of this vulnerable population. This includes broader implementation of affordable and evidence-based treatments, such as doctor-patient collaborative care models and cognitive-behavioral therapy. Additionally, greater access to behavioral health providers, especially in underserved areas is important, as is healthcare systems change that supports suicide prevention and patient safety through care transitions [11].

While mental health problems are a significant contributor to suicide, 54% of suicide decedents in this study did *not* have a known MHP. This group suffered more relationship problems and life stressors such as criminal-legal matters, eviction/loss of home, and recent or impending crises. This is noteworthy in light of findings that suggest many suicides and attempts occur with minimal deliberation time, particularly among people without mental health disorders and who faced impending life crises [12].

Comment [FC(]: I think the comparison group %'s are needed. For instance, drugs (35.8% vs. 35.8%).

I think the presentation of the %'s would be easier here and later on in the results if the p's came out and the text could simply reflect "significant differences" or some variation of indicating in the groups were different.

Comment [FC(]: The % reported in this sentence appear to be only for the group with MHPs. Based on the sentence wording, the % for both groups need to be reported.

Comment [FC(]: Please double check number. Table reflects 33.8%

Comment [FC(]: My two cents: I think we should do more to raise attention to the fact that almost a quarter of both groups disclosed suicide intent. This is a true prevention opportunity so I think this is a common risk to highlight. Knowing space constraints, I think this is more important to highlight than the presence of a suicide note which often doesn't inform prevention. I suggest adding into results and into discussion.

Comment [FC(]: I feel that MMWRs typically don't do a lot of repeat of the specific data findings in the discussion. I think the numbers could come out here. I think it would be helpful to put this into a larger context, indicating whether this is consistent with other research. I also think this is an opportunity to start the narrative that suicide risks are not only MHP. I'd also suggest slight revision to

People with known MHP also experienced other life stressors such as job and/or financial problems, relationship problems, and physical health problems. These findings point to the need to both prevent the conditions associated with mental health problems in the first place and the need to support people with MHP to decrease their vulnerability to poor social, health, and economic outcomes [13].

These results underscore the importance of comprehensive state suicide prevention activities that go beyond a focus on ~~MH~~mental health treatment alone. Prevention strategies may include: strengthening economic supports (e.g., housing stabilization policies, household financial support); teaching coping and problem-solving skills, especially early in life to manage everyday stressors and prevent future relationship problems; and promoting social connectedness to increase a sense of belongingness and access to informational, tangible, emotional, and social support, as needed. Other strategies ~~indicated by these results~~ include creating protective environments (e.g., reducing access to lethal means among people at risk, creating organizational and workplace policies to promote help-seeking and positive social norms), supporting family and friends after a suicide has taken place, and assuring safe reporting by the media in order to prevent suicide contagion [11]. Some states, such as Colorado, are planning and implementing a comprehensive approach to suicide prevention [14].

The study findings have at least three limitations. In the state-level analysis, rankings for four states (MD, MA, RI, UT) might have been impacted by large proportions of injury deaths of undetermined intent, or by decreased percentages of such deaths over time, which likely include some unrecognized suicides. Second, NVDRS is not yet nationally representative, and this study's ~~. This study used the most current data available which~~ data includedes ~~27 states that represent half (~~49.6%~~)~~ of the U.S. population. Third, abstractors of NVDRS data are limited to data included in investigative reports. ~~For example, m~~Medical and ~~MH~~mental health information ~~are not captured directly from medical records but~~ come from key informants (e.g., family, friends) via coroner/medical examiner reports and can ~~. Therefore, informant knowledge~~ impacts ~~the~~data completeness and accuracy~~. of the information reported, and~~ Some studies including in-depth interviews with family members show ~~often see~~ greater attributions to ~~MH~~mental health and substance abuse disorders than medical records~~, however methodological variation across studies exists~~ [15]. It is likely that some people without known MHP in the current study were experiencing mental health challenges at the time of death that were either not known or reported by informants~~, or were not captured in NVDRS's primary data sources. The lack of awareness of a mental health problem suggests the importance of addressing the range of contributing circumstances~~.

Suicide is a growing public health problem. Mental illness is an important risk factor for suicide, and is one of many requiring preventive action. Data from NVDRS and resources such as CDC's *Preventing Suicide: a Technical Package of Policies, Programs, and Practices* [11] can help states and communities better understand their suicide problem and prioritize comprehensive suicide prevention.

Acknowledgments
The authors acknowledge Robert Anderson, Holly Hedegaard, and Margaret Warner from the Division of Vital Statistics, National Center for Health Statistics, CDC, for their statistical consultation.

Conflict of Interest No conflicts of interest were reported.

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Comment [FC(]: I suggest pulling this out into a separate paragraph. If contained in the above, it seems to undercut the main point that many suicides don't have MPH. A new paragraph might need a lead-in sentence or maybe start with the current last sentence to frame points about common risks.

Comment [FC(]: I think it is fine that the TP strategies are presented in different areas of the discussion. I don't easily see "identify and support people at-risk". I think that can go in the proposed paragraph immediately above when talking about common risk factors. In adding that, suggest adding some examples of approaches (e.g., crisis intervention, gatekeeper training).

Comment [FC(]: I am not easily following this point. Can this be stated more simply such as "…impacted by variations of undetermined injury deaths, which likely….

To help w/word count, offer a couple of suggestions in next few sentences to streamline. Certainly take/leave what you like and check for accuracy.

Comment [FC(]: To me, this sentence puts the spotlight back on mental illness and makes it likely it will be the take home message of media reporting. If that isn't the goal of this VS, suggest framing broadly. Ideas: *Effective approaches are available to prevent or ameliorate many suicide risk factors, such as depression and anxiety, recent crisis, substance use, intimate partner problems, and financial problems. –*OR*—No one factor causes suicide so preventive action must address multiple factors, such as XX*

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Tables and Figures (attachments)

Table 1 and Figure 1.doc

Tables 2 and 3.pdf

Word Count: 1826/1800

DRAFT

From: Ballman, Marie R. (CDC/ONDIEH/NCIPC)
Sent: 25 May 2018 14:00:05 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Q&As

Thanks. I have passed this along.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 24, 2018 12:34 PM
To: Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Q&As

Thanks, Marie. I think we have this covered with this question.

Are the people without mental health conditions just people who haven't been diagnosed with a mental health conditions?

It is possible that the people without mental health conditions in this study had a diagnosable mental health condition but had not been diagnosed, or that their mental health conditions was unknown to informants who provided circumstantial information to law enforcement. Studies including more in-depth interviews with next-of-kin often cite greater attributions to mental disorders, however many methodological variations across studies exist. It is likely that some people without known mental health conditions in the current study were experiencing mental health challenges that were unknown, and hence underreported by key informants. Nonetheless, the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Deb

From: Ballman, Marie R. (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 24, 2018 7:39 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: Q&As

It seems the following might be alluded to in a previous version of the Q&A's I found in email. But it might be worth ensuring this question or similar is in the Q&As.

Do we know if suicide is truly MORE than a mental health issue or is it more that it's a problem of UNDIAGNOSED and therefore untreated mental health conditions? (Mentioned that men might be less likely to seek help, receive diagnosis, etc.) And would this change or shift a prevention approach?

This question came from Katherine Lyon Daniel.

Please let me know if you are adding or if you feel it is already addressed.

Thanks,

Marie

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 23, 2018 3:54 PM
To: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Subject: RE: Q&As

Ok, thanks. I think Marie may have another question to add too. CC'ing her here.

Deb

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 1 Jun 2018 19:14:02 +0000
To: Sokler, Lynn (CDC/OD/OADC);Simon, Thomas (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Cc: Omisore, Shannon L. (CDC/OD/OADC);Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID);Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Subject: RE: QA document

Great, thank you!
Deb

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, June 1, 2018 3:00 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD)
Cc: Omisore, Shannon L. (CDC/OD/OADC) ; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) ; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Subject: RE: QA document

I meant Roybal, Building 21, the 12th floor, conference room 12116

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, June 1, 2018 2:55 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: QA document

Thanks Deb, for your kind words! I've answered below. Feel free to let us know if you have any other questions. Lynn

---

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 2:45 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: RE: QA document

Hi Lynn,
Thank you very much for this run down (and for everything else while I'm at it!)!
A few questions:

- Should I be at Roybal on Wed pm? You can do any interviews on Weds from your office. Thurs is when you will want come to Roybal. The pre-brief and telebriefing are held on the 12th floor, conference room 12116. It is a smaller room in the middle of the floor.
- Is NPHIC to get the material on Thursday at 9 as well? Yes, NMB will send out to NPHIC.

- Also we have the CAN number for printing but sounds like we need a formal authorization. When do you need this by? Yes, we'd like to have all (including formal authorization of funds from your MO) by COB Monday, if possible.

Thanks,
Deb

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, June 1, 2018 2:32 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>
Subject: RE: QA document

Just got ASPA final clearance on materials with no further changes. We'll make your last changes to FS and will now be final on the Fact Sheet and Press Release. (no more changes).
Next week:

MON-WEDS

- Finalize all other materials.
- Send Fact Sheet to printer. Must deliver copies to CDCW by COB on Weds. Still need your quantity, CAN # and MO written authorization). ATL copies will deliver by Thurs afternoon or Friday to mail rooms.
- Translate Spanish – press release, and social media
- Build VS website, program reviews, finalize website
- Send final materials to everyone (Weds around 2 pm), to OD, senior leaders, VS distributors.
- Media advisory out – Tues, again Weds., with final materials on Thurs.
- Pre-embargoed media interviews with national media – Dr. Schuchat does on Weds afternoon and Thurs am.

THURS 9 AM

- Critical Contacts email – sent by Dr. Schuchat with materials
- OSTLTS materials distribution – ASTHO, NAACHO, CSTE, APHL, includes SHOs
- **Program** partner distribution with materials, including state and local violence prevention coordinators
- CDC W – Hill Alert with materials and hard copy Fact Sheets to policy makers
- Media advisory and materials distribution – to CDC media list and on wire
- Medical media and collaborators materials distribution
- **Media Telebriefing – 12-12:45 pm**-
- Materials are LIVE on web – 1 pm. Materials are off embargo.
- Other media interviews – Deb Stone – as requested
- Facebook and Twitter posts out over two weeks, other social media.
- CDC Gov-D announcement goes out
- HHS promotes VS on their social media handles

Hope this helps. And you've done at great job of "rounding everything up" for your first rodeo. I will miss being here with you for the launch, but know there will be a lot of attention to this.
Lynn

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 2:10 PM

To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: QA document

I did not know it is going back to ASPA. When will they provide comments?
Can you all provide a sense of the schedule for next week? This our first VS rodeo and we aren't sure what to expect.
Thank you, Tom

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, June 1, 2018 2:02 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: QA document

Thanks. We are sending the materials to Anne now. The FS will go as we have it currently. We'll make Tom's suggested changes once we have comments from ASPA as well. Thanks everyone!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 1:59 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: RE: QA document

Hi Lynn,
Here you go!! Thanks for your patience!
Deb

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, June 1, 2018 1:56 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: QA document

Hi Folks, I need to have the QA document now to send with other materials to Anne. She's waiting on them. Please send as soon as you can.
Thanks, Lynn

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, June 1, 2018 12:16 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: June VS: Related Links, Deadlines

Deb,
Sorry for the confusion. I meant to say that the related links are due by Monday at Noon.
Thanks,

Shannon

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 12:02 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: June VS: Related Links, Deadlines

Hi Shannon,
So the related links deadline is changed from June 4 at noon to today at noon (now)? Also, did you get our printing info emailed to you?
Deb

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, June 1, 2018 11:59 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: June VS: Related Links, Deadlines

Hi all,
As a friendly reminder, the related links are due. Please send the related links by Noon on Friday.
Deadlines are listed below:
Fact sheet and Q&As, due by today, June 1 at 2 pm
Approval email and information for printing, due by COB today, June 1
Related links, due by Monday, June 4 at Noon
Thanks,
Shannon

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Thursday, May 24, 2018 10:02 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: fact sheet

Hi Tom,
Please plan to incorporate additional changes in the version of the FS that addresses HHS/ASPA comments. I need the related links by Wednesday, May 30. For samples of the related links, see previous VS (for example: https://www.cdc.gov/vitalsigns/containing-unusual-resistance/index.html). The MMWR and Medline Plus links are provided by VS staff. For the PR graphic, it will consist of the map, headline, legend, and source from the top of page 2. Adding the graphic at the bottom of page 2 to the PR graphic would make it look too busy.
Thanks,
Shannon

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 24, 2018 9:20 AM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC)

<zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: fact sheet

Hi Shannon,

Thank you for the update. We have some edits to the FS as well. Should we plan to incorporate them in the version we send back to you that addresses HHS/ASPA comments? When will you need that back from us?

Please see responses to your points below. Crystal, please check this out too.

Thank you,

-Tom

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Wednesday, May 23, 2018 11:10 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: fact sheet

Hi Tom and all,

We will probably get feedback from HHS/ASPA by COB on Friday, May 25. However, we can't guarantee that we'll receive the feedback by that date. Please see below.

1. What would you like to use for the PR graphic? For the PR graphic, we suggest that it include the top graphic on page 2 (Suicide rates rose…) and the middle graphic (Differences exist).

We agree with using the map from page 2. If there is a second image it would be great to include the circumstance figure from the bottom of page 3.

2. For page 3 of the fact sheet, the following change will be made to the note for clear language: delete "Suicide decedent". Insert "Persons who died by suicide".

This makes sense.

3. Please provide the related links for the June VS. The two categories for related links are Related Pages (internal CDC links) and Other Sites (external links). Please have the hyperlink embedded in the description (for example, MedlinePlus – Antibiotic Resistance)

When do you need this by? Do have an example that you can share with us. How many of each do you include? Crystal, is this something that you or someone from communications can draft for Deb and I to review?

Thanks,

Shannon

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 23, 2018 10:09 AM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Castro Perdomo, Julio (CDC/OD/OADC) (CTR) <vij7@cdc.gov>; Vital Signs Web (CDC) <vitalsignsweb@cdc.gov>; McDaniel, Rebecca (CDC/OD/OADC) (CTR) <ldy8@cdc.gov>; Lansdale, Ashley (CDC/OD/OADC) (CTR) <ohz8@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A.

(CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi Shannon,

Are we still anticipating feedback from ASPA and HHS by cob today? When will you need changes back from us?

Thank you,

Tom

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Wednesday, May 23, 2018 7:46 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Castro Perdomo, Julio (CDC/OD/OADC) (CTR) <vij7@cdc.gov>; Vital Signs Web (CDC) <vitalsignsweb@cdc.gov>; McDaniel, Rebecca (CDC/OD/OADC) (CTR) <ldy8@cdc.gov>; Lansdale, Ashley (CDC/OD/OADC) (CTR) <ohz8@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi all,

Attached is the June VS fact sheet. This includes the latest change (the word just was deleted).

Shannon

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 18, 2018 4:12 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi Lynn,

Ok, thank you. Our Communication director suggested that we drop this to avoid sounding like we are minimizing mental health conditions. We were hoping to do that before it went to HHS and ASPA.

Tom

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, May 18, 2018 4:08 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: fact sheet

HI Tom,

Shannon has gone for today so I'll respond. Unfortunately the graphics team has gone and the package is in prep to go to ASPA. We're happy to make the change next week while we wait for comments to come back from HHS staffdivs and opdivs. There will be other changes to make in responding to their comments, so this isn't the final of the fact sheet.

Thanks, Lynn

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 18, 2018 3:59 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi Shannon,
Is it too late to remove the word "just" from the subtitle at the top of page one?
Thank you, Tom

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, May 18, 2018 2:21 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Tom,
I have discussed page 3 with Lynn and the graphic artist. The current Warning Signs graphic is a major improvement from what was there before. This version encourages the reader to read from left to right, which is ideal. It also can stand alone as a graphic to be tweeted out or posted in for example, a doctor's office. So, we suggest that it remain as is. An additional change for the fact sheet is for "healthcare systems" to be changed to "health care systems" for Vital Signs style requirements.
Thanks,
Shannon

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 18, 2018 1:06 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi Shannon,
Overall this looks very good. Given the time limit we skimmed it quickly and had a few suggestions. I just used stickies to indicate these in the pdf. Hopefully these can be made before this goes forward.
In addition to these, we aren't sure about the checkerboard for the warning signs. It seems to make the page busier. What do you all think? We'll ask our communication folks to be looking at this too and might have suggestions next week.
Thank you!
-Tom

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, May 18, 2018 11:25 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi Tom,
Attached is the updated June VS FS, which includes changes that I've indicated on stickies. Please send any additional changes by 1 pm today, Friday, May 18.
Thanks,
Shannon

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 17, 2018 5:43 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: fact sheet

Hi Shannon,
I just spoke with Deb and we want to make one additional change to the FS. The bubble at the bottom of page 2 should be "problematic substance use."
We made the change to the Word doc (attached).
What is the next step with the FS? Will we get to review it before it goes to HHS?
Best, Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 1 Jun 2018 18:44:48 +0000
To: Sokler, Lynn (CDC/OD/OADC);Simon, Thomas (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Cc: Omisore, Shannon L. (CDC/OD/OADC);Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID);Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Subject: RE: QA document

Hi Lynn,
Thank you very much for this run down (and for everything else while I'm at it!)!
A few questions:

- Should I be at Roybal on Wed pm?
- Is NPHIC to get the material on Thursday at 9 as well?
- Also we have the CAN number for printing but sounds like we need a formal authorization. When do you need this by?

Thanks,
Deb

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, June 1, 2018 2:32 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD)
Cc: Omisore, Shannon L. (CDC/OD/OADC) ; Sokler, Lynn (CDC/OD/OADC) ; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) ; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID)
Subject: RE: QA document

Just got ASPA final clearance on materials with no further changes. We'll make your last changes to FS and will now be final on the Fact Sheet and Press Release. (no more changes).
Next week:

MON-WEDS

- Finalize all other materials.
- Send Fact Sheet to printer. Must deliver copies to CDCW by COB on Weds. Still need your quantity, CAN # and MO written authorization). ATL copies will deliver by Thurs afternoon or Friday to mail rooms.
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- Send final materials to everyone (Weds around 2 pm), to OD, senior leaders, VS distributors.
- Media advisory out – Tues, again Weds., with final materials on Thurs.
- Pre-embargoed media interviews with national media – Dr. Schuchat does on Weds afternoon and Thurs am.

THURS 9 AM

- Critical Contacts email – sent by Dr. Schuchat with materials
- OSTLTS materials distribution – ASTHO, NAACHO, CSTE, APHL, includes SHOs
- **Program** partner distribution with materials, including state and local violence prevention coordinators
- CDC W – Hill Alert with materials and hard copy Fact Sheets to policy makers
- Media advisory and materials distribution – to CDC media list and on wire
- Medical media and collaborators materials distribution
- **Media Telebriefing – 12-12:45 pm**-

- Materials are LIVE on web – 1 pm. Materials are off embargo.
- Other media interviews – Deb Stone – as requested
- Facebook and Twitter posts out over two weeks, other social media.
- CDC Gov-D announcement goes out
- HHS promotes VS on their social media handles

Hope this helps. And you've done at great job of "rounding everything up" for your first rodeo. I will miss being here with you for the launch, but know there will be a lot of attention to this.
Lynn

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 2:10 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: QA document

I did not know it is going back to ASPA. When will they provide comments?
Can you all provide a sense of the schedule for next week? This our first VS rodeo and we aren't sure what to expect.
Thank you, Tom

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, June 1, 2018 2:02 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: QA document

Thanks. We are sending the materials to Anne now. The FS will go as we have it currently. We'll make Tom's suggested changes once we have comments from ASPA as well. Thanks everyone!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 1:59 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: RE: QA document

Hi Lynn,
Here you go!! Thanks for your patience!
Deb

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, June 1, 2018 1:56 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: QA document

Hi Folks, I need to have the QA document now to send with other materials to Anne. She's waiting on them. Please send as soon as you can.
Thanks, Lynn

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, June 1, 2018 12:16 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: June VS: Related Links, Deadlines

Deb,
Sorry for the confusion. I meant to say that the related links are due by Monday at Noon.
Thanks,
Shannon

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 12:02 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: June VS: Related Links, Deadlines

Hi Shannon,
So the related links deadline is changed from June 4 at noon to today at noon (now)? Also, did you get our printing info emailed to you?
Deb

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, June 1, 2018 11:59 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: June VS: Related Links, Deadlines

Hi all,
As a friendly reminder, the related links are due. Please send the related links by Noon on Friday.
Deadlines are listed below:
Fact sheet and Q&As, due by today, June 1 at 2 pm
Approval email and information for printing, due by COB today, June 1
Related links, due by Monday, June 4 at Noon
Thanks,
Shannon

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Thursday, May 24, 2018 10:02 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: fact sheet

Hi Tom,

Please plan to incorporate additional changes in the version of the FS that addresses HHS/ASPA comments. I need the related links by Wednesday, May 30. For samples of the related links, see previous VS (for example: https://www.cdc.gov/vitalsigns/containing-unusual-resistance/index.html). The MMWR and Medline Plus links are provided by VS staff. For the PR graphic, it will consist of the map, headline, legend, and source from the top of page 2. Adding the graphic at the bottom of page 2 to the PR graphic would make it look too busy.
Thanks,
Shannon

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 24, 2018 9:20 AM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: fact sheet

Hi Shannon,
Thank you for the update. We have some edits to the FS as well. Should we plan to incorporate them in the version we send back to you that addresses HHS/ASPA comments? When will you need that back from us?
Please see responses to your points below. Crystal, please check this out too.
Thank you,
-Tom

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Wednesday, May 23, 2018 11:10 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: fact sheet

Hi Tom and all,
We will probably get feedback from HHS/ASPA by COB on Friday, May 25. However, we can't guarantee that we'll receive the feedback by that date. Please see below.

1. What would you like to use for the PR graphic? For the PR graphic, we suggest that it include the top graphic on page 2 (Suicide rates rose…) and the middle graphic (Differences exist).

We agree with using the map from page 2. If there is a second image it would be great to include the circumstance figure from the bottom of page 3.

2. For page 3 of the fact sheet, the following change will be made to the note for clear language: delete "Suicide decedent". Insert "Persons who died by suicide".

This makes sense.

3. Please provide the related links for the June VS. The two categories for related links are Related Pages (internal CDC links) and Other Sites (external links). Please have the hyperlink embedded in the description (for example, MedlinePlus – Antibiotic Resistance)

When do you need this by? Do have an example that you can share with us. How many of each do you include? Crystal, is this something that you or someone from communications can draft for Deb and I to review?

Thanks,
Shannon

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 23, 2018 10:09 AM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Castro Perdomo, Julio (CDC/OD/OADC) (CTR) <vij7@cdc.gov>; Vital Signs Web (CDC) <vitalsignsweb@cdc.gov>; McDaniel, Rebecca (CDC/OD/OADC) (CTR) <ldy8@cdc.gov>; Lansdale, Ashley (CDC/OD/OADC) (CTR) <ohz8@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi Shannon,
Are we still anticipating feedback from ASPA and HHS by cob today? When will you need changes back from us?
Thank you,
Tom

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Wednesday, May 23, 2018 7:46 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Castro Perdomo, Julio (CDC/OD/OADC) (CTR) <vij7@cdc.gov>; Vital Signs Web (CDC) <vitalsignsweb@cdc.gov>; McDaniel, Rebecca (CDC/OD/OADC) (CTR) <ldy8@cdc.gov>; Lansdale, Ashley (CDC/OD/OADC) (CTR) <ohz8@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi all,
Attached is the June VS fact sheet. This includes the latest change (the word just was deleted).
Shannon

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 18, 2018 4:12 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi Lynn,
Ok, thank you. Our Communication director suggested that we drop this to avoid sounding like we are minimizing mental health conditions. We were hoping to do that before it went to HHS and ASPA.
Tom

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, May 18, 2018 4:08 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>

Cc: Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Subject: RE: fact sheet

HI Tom,

Shannon has gone for today so I'll respond. Unfortunately the graphics team has gone and the package is in prep to go to ASPA. We're happy to make the change next week while we wait for comments to come back from HHS staffdivs and opdivs. There will be other changes to make in responding to their comments, so this isn't the final of the fact sheet.

Thanks, Lynn

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 18, 2018 3:59 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi Shannon,

Is it too late to remove the word "just" from the subtitle at the top of page one?

Thank you, Tom

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, May 18, 2018 2:21 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Tom,

I have discussed page 3 with Lynn and the graphic artist. The current Warning Signs graphic is a major improvement from what was there before. This version encourages the reader to read from left to right, which is ideal. It also can stand alone as a graphic to be tweeted out or posted in for example, a doctor's office. So, we suggest that it remain as is. An additional change for the fact sheet is for "healthcare systems" to be changed to "health care systems" for Vital Signs style requirements.

Thanks,

Shannon

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 18, 2018 1:06 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi Shannon,

Overall this looks very good. Given the time limit we skimmed it quickly and had a few suggestions. I just used stickies to indicate these in the pdf. Hopefully these can be made before this goes forward.

In addition to these, we aren't sure about the checkerboard for the warning signs. It seems to make the page busier. What do you all think? We'll ask our communication folks to be looking at this too and might have suggestions next week.

Thank you!

-Tom

From: Omisore, Shannon L. (CDC/OD/OADC)
Sent: Friday, May 18, 2018 11:25 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>
Subject: RE: fact sheet

Hi Tom,
Attached is the updated June VS FS, which includes changes that I've indicated on stickies. Please send any additional changes by 1 pm today, Friday, May 18.
Thanks,
Shannon

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 17, 2018 5:43 PM
To: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: fact sheet

Hi Shannon,
I just spoke with Deb and we want to make one additional change to the FS. The bubble at the bottom of page 2 should be "problematic substance use."
We made the change to the Word doc (attached).
What is the next step with the FS? Will we get to review it before it goes to HHS?
Best, Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 17 Apr 2018 01:50:37 +0000
To: Black, Erin (CDC/ONDIEH/NCIPC);Ikeda, Robin (CDC/ONDIEH/OD)
Cc: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Subject: RE: Question RE: AAS Conference Logistics
Attachments: injuryprev-2017-042366.full.pd.pdf, CNC One Pager_11Jan18 ds.pdf

Hi Robin and Erin,
I made some notes on the one pager attached.

- In general, the Colorado national collaborative (CNC) is still very much in the planning phase. (per Erin's email below, we are just in the beginning phase of Phase 1 (Strategic planning for collective community action, which will bring together state and county stakeholders to create a shared agenda). So far funds are extremely limited. I would say that yes, the project is reliant on an infusion of funds through CDCF or elsewhere. So far the CNC has met with 3 of the selected counties and has gotten their buy in. Meetings with the other 3 will take place later in the year.
- Apart from a lack of funds, the CNC is grappling with how best to roll out (and then evaluate) comprehensive and integrated (health and community based interventions) prevention in 6 counties, using data to drive planning and considering the social ecological model, upstream and downstream approaches, and a community driven process.
- I think it would be strategic to mention the technical package (of course), transforming communities* (came out of the transforming communities task force of the action alliance), possibly **zero suicide** if you can work it in since this is part and parcel of comprehensive and integrated prevention and is where a lot of the momentum in the field is right now and we should be supportive of it (while at the same time pushing for upstream primary prevention).

*The transforming communities was meant to be to communities what zero suicide is for healthcare systems.
Might also want to hint about our vital signs without giving it away as I believe Dr. Schuchat did at the action alliance meeting.

- Looking at trends in state suicide prevention rates over time (1999-2016) and assessing the multiple risk factors for suicide, including but not limited to mental health problems.

I hope this is helpful and I hope it's not too much.
Deb

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Monday, April 16, 2018 4:10 PM
To: Ikeda, Robin (CDC/ONDIEH/OD)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Subject: FW: Question RE: AAS Conference Logistics

Hi Robin - Below is some info that might be useful, I am copying Deb Stone, the POC for the CO project. She is out of the office today but I have copied her to add additional information. What are the specific activities that CO intends to pilot test and evaluate as part of this initiative? Realize this may still be in early stages of discussion/development, but if some decisions have already been made, am curious to know.

The Colorado National Collaborative (CNC) was formed in 2015 by the Colorado Department of Public Health and Environment (CDPHE) and the Colorado Suicide Prevention Commission, in collaboration with the CDC-funded Injury Control Research Center for Suicide Prevention (ICRC-S), the National Action Alliance for Suicide Prevention (Action Alliance) and the American

Foundation for Suicide Prevention (AFSP). **A one page fact sheet about the CNC is attached.** Deb can update you on where the CNC is in their implementation of the tasks described in the one pager. The Colorado National Collaborative hopes to:

- Identify and prevent suicide in counties with the highest rates
- Engage partners from counties facing high suicide rates
- Facilitate and strengthen coordinated suicide prevention action plans
- Implement coordinated prevention plans to ensure cost-effective and sustainable change
- Evaluate progress and outcomes in order to support continual improvement

This is a 5-year project with implementation in three phases. Currently they are in phase 1 of implementation:

- **Phase 1**: Strategic planning for collective community action, which will bring together state and county stakeholders to create a shared agenda, timeline and milestones for moving forward, using the transforming communities (TC) process and the CDC technical package. This phase will also include the drafting of community grants that will be available to counties for implementing suicide prevention activities in Phase 2. Providing technical assistance to potential applicants will serve as a powerful tool for enhancing their understanding and skills to define and develop locally applicable, evidence-based activities.
- **Phase 2:** Continued local roll-out of TC, uptake of the CDC technical package and awards of community grants in the 6 targeted counties.
- **Phase 3**: Preparation of a field-informed dissemination package and plan for guiding efforts to achieve coordinated, comprehensive suicide prevention efforts in Colorado statewide and in other states and communities nationwide.

Have some activities for this initiative already gotten underway, or are they dependent on receipt of CDC/F funding?

- Partnership engagement in Colorado and specifically in those counties that have the highest suicide rates has already begun. Some funding has already been secured by the CNC, however, the project will not reach the state goal to reduce suicide 20% by 2024, nor help the nation move toward its goal, to reduce the suicide rate 20% by 2025, without an infusion of national level support.

From: Ikeda, Robin (CDC/ONDIEH/OD)
Sent: Monday, April 16, 2018 10:10 AM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: Question RE: AAS Conference Logistics

Thanks. Quick questions:

- What are the specific activities that CO intends to pilot test and evaluate as part of this initiative? Realize this may still be in early stages of discussion/development, but if some decisions have already been made, am curious to know.
- Have some activities for this initiative already gotten underway, or are they dependent on receipt of CDC/F funding?

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Monday, April 16, 2018 9:50 AM
To: Ikeda, Robin (CDC/ONDIEH/OD) <rmi0@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC)

<epm7@cdc.gov>
Subject: RE: Question RE: AAS Conference Logistics
Totally fine! :) Erin might know that answer quickly. (If I remember correctly, that's a cross-Division project with DARPI—so, Erin, if there's someone in DARPI I need to connect with, just let me know.)

From: Ikeda, Robin (CDC/ONDIEH/OD)
Sent: Monday, April 16, 2018 9:48 AM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: Question RE: AAS Conference Logistics
Thanks! I also have a couple questions about the work in CO – who is the POC for that? Sorry for multiple emails!

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Monday, April 16, 2018 9:46 AM
To: Ikeda, Robin (CDC/ONDIEH/OD) <rmi0@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: Question RE: AAS Conference Logistics
Hi Robin,
J Logan in DVP is the lead for this project. I'm cc'ing in Erin in DVP to connect you and J.
Thanks,
Leslie

From: Ikeda, Robin (CDC/ONDIEH/OD)
Sent: Sunday, April 15, 2018 4:33 PM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>
Subject: Question RE: AAS Conference Logistics
Hi Leslie,
Many thanks again for sending all this material. Is there someone I could chat with about the TalkVet initiative? It sounds quite innovative/interesting, so I want to make sure I understand how it works and what is planned.
Thank you.
Robin

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Tuesday, March 13, 2018 1:33 PM
To: Ikeda, Robin (CDC/ONDIEH/OD) <rmi0@cdc.gov>
Cc: Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>
Subject: RE: AAS Conference Logistics
Hi Robin,
Attached are some talking points for the upcoming AAS plenary. These are similar to TPs prepared for Dr. Schuchat for a Suicide Action Alliance Executive Committee Meeting that occurred this week, plus we've added some recent activities to the document. Below are two proposed questions as requested by the panel moderator.
Also, I've also included below some recent headlines about suicide from our 3x/weekly scan of news articles for our Center's key topics. Thought this might be helpful in terms of thinking about what might be on top of mind for the conference attendees.
Please let me know if there's anything else you need for this!
Thank you,
Leslie
Proposed Questions:

- What does primary prevention of suicide look like?
- Why is having national, state, and local surveillance data important for suicide prevention? What can be done to strengthen the data currently available or explore new areas?

Recent stories about suicide in the news:

How families, communities can discuss youth suicide (CDC mention) AP Mississippi
Why living in high altitudes raises depression, suicide risks Yahoo
With Utah governor's suicide task force urging action, lawmakers back two prevention bills (CDC mention) Salt Lake City Tribune
Child suicide, the agony of 'Why?' (CDC mention) Washington Post
As Milk Prices Decline, Worries About Dairy Farmer Suicides Rise (CDC mention) National Public Radio
Milk co-op mailing highlights suicide risk for dairy farmers Associated Press
Police: Student who committed suicide at Ohio middle school planned school massacre CBS News
Suicide Rates Increase in Puerto Rico Following Hurricane Maria People
One Key Factor Raises Gay and Lesbian Teens' Suicide RiskU.S. News
Suicide isn't just a 'white people thing ' Salon
Aiming to combat teen suicide, Georgia turns to social media Associated Press
Drug-overdose suicides may be going undetected Reuters
Identifying Youth at Risk for Suicide MedPage Today
New partnership hopes to tackle military suicides The Gazette

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From: Ikeda, Robin (CDC/ONDIEH/OD)
Sent: Thursday, March 1, 2018 1:03 PM
To: Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>
Subject: RE: AAS Conference Logistics

Thank you, thank you, thank you!

From: Dorigo, Leslie (CDC/ONDIEH/NCIPC)
Sent: Thursday, March 1, 2018 1:00 PM
To: Ikeda, Robin (CDC/ONDIEH/OD) <rmi0@cdc.gov>; Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>
Subject: RE: AAS Conference Logistics

Happy to help with prep! We'll get you something in advance of their deadline.

From: Ikeda, Robin (CDC/ONDIEH/OD)
Sent: Thursday, March 1, 2018 12:54 PM
To: Peeples, Amy B. (CDC/ONDIEH/NCIPC) <asb0@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>
Subject: FW: AAS Conference Logistics

Hi – I am scheduled to participate on this panel at the AAS meeting in April (I'm filling in for Deb, who is not available that day ☺).
Although I will not be "presenting" per se, it would be helpful to have talking points of things to mention (or work into the panel discussion as appropriate). Also, if you have suggestions for the 1-2 questions for Jerry to ask (see highlight), please let me know. Thanks so much; appreciate your help.
Robin

Dear Colleagues,
Below you will see the posting in the upcoming conference guide for the American Association of Suicidology Conference scheduled for April 18-21, 2018 at the Hyatt Regency on Capitol Hill. Our session

is scheduled for Friday, April 20th from 9:30 – 10:15 AM. I do not plan to have any PowerPoint presentations but instead to just engage in a conversation with the five of you. I am writing to ask you to please feel free to send me a question or two that you would like to answer for the audience who will assemble to hear this plenary. I am quite open to your input especially if there is anything you would very much like to highlight for the group. You can see the written narrative of the session below. My hope is that each of you will speak to aligning our efforts to contribute to the collective impact possible by working together. Our collective approach is to reduce the rate of suicide by 20% by 2025. If you could send me a question or two by Friday, March 16th, I would be most grateful. Enjoy the weekend. Best and thank you all for your willingness to participate.

Best,

Jerry

Jerry Reed, PhD, MSW
Senior Vice President for Practice Leadership
Suicide, Violence & Injury Prevention Portfolio Lead
National Action Alliance for Suicide Prevention Executive Committee Member
jreed@edc.org | 202-572-3771 (O) | 202-294-8132 (M) | 202-223-4059 (F)
Education Development Center, Inc.

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Morning Plenary Highlights

Friday, April 20th

Aligning Efforts in the Public Sector: the National Response to Suicide



Robin M. Ikeda, MD, MPH, Deputy Director, Office of Noncommunicable Diseases, Injury and Environmental Health, Centers for Disease Control and Prevention



Anita Everett, MD, DFAPA, Chief Medical Officer, Office of the Chief Medical Officer, SAMHSA



Keita Franklin, LCSW, PhD, Director, Defense Suicide Prevention Office, Office of the Under Secretary for Personnel and Readiness



Carolyn Clancy, MD, MACP, Executive in Charge, Veterans Health Administration



Joshua Gordon, MD, PhD, Director, National Institute of Mental Health



Moderator: Jerry Reed, PhD, Senior Vice President for Practice Leadership & Director, Suicide, Violence, and Injury Prevention Portfolio, Education Development Center, Inc.

A distinguished panel of federal senior leaders from the Department of Defense, the Department of Veterans Affairs and the Department of Health and Human Services (specifically the Centers for Disease Control and Prevention, the National Institute of Mental Health, and the Substance Abuse and Mental Health Services Administration), moderated by Dr. Jerry Reed, long-time AAS member from EDC, Inc., will discuss how each agency contributes to suicide prevention efforts in our nation. With our collective public-private goal to reduce the national rate of suicide by 20% by 2025, it is imperative that each department or operational division, in conjunction with the efforts of other private and philanthropic sectors do their part to ensure we apply the evidence of what we know in a manner that will allow us to reduce morbidity and mortality following suicidal behavior. We will address how political will, a social strategy, and a sound knowledge base are all necessary to achieve the collective impact of reduced suicidal behavior in our country. Panelists bring various perspectives such as public and mental health approaches as well as awareness of key at risk populations and the evidence to enrich our understanding of approaches and settings which should be part of our local, state, tribal, and national approaches. Panel members will engage in a dialogue with the moderator to more clearly understand how surveillance, research, practice, and services must be comprehensive, integrated and taken into consideration to reduce lives lost to suicide.

Dear Jerry:

I am contacting you regarding the logistics related to your participation at the AAS Annual Conference in Washington, DC:

- You are scheduled to moderate a Plenary Panel on Friday, April 20th at 9:30am to 10:15am. It will be held in the Regency Ballroom on the First Floor of the Hyatt Regency. As the moderator

and given that EDC took the lead on assembling the panelists, please let me know if you will be communicating with the panelists regarding these arrangements or if you would like me to do so.

- If the panel is using Power Point, please email the presentation to me no later than Monday, April 16th to ajkulp@suicidology.org. An alternative is to bring the presentation on a flash drive and we can load it into the lap top for you. Either way, please confirm your intentions.
- Please plan to check in with the onsite AV technician between 7:30 and 8:00 the morning of your presentation. This will ensure a smooth transition for the general session.
- We are planning to adhere very closely to our morning schedule. We will have someone seated down front to assist you with tracking the time. He/she will discretely hold up signs at five, three, and one minutes remaining. We will also have a clock on the podium. Your attention to these would be greatly appreciated.

I appreciate your attention to these details. Please contact me if I can be of any assistance. FYI—I will be onsite at the Hyatt on April 16th. I can be reached via cell phone at 410-746-2588 should you need to reach me prior to your arrival.

Regards,

Amy
Amy Kulp, M.S.
Deputy Director
American Association of Suicidology
5221 Wisconsin Avenue, NW
Washington, DC 20015
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Join us for our 51st Annual Conference, April 18-21, 2018 in Washington, DC

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

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Comprehensive, integrated approaches to suicide prevention: practical guidance

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ABSTRACT

Background Efforts in the USA during the 21st century to stem the ever-rising tide of suicide and risk-related premature deaths, such as those caused by drug intoxications, have failed. Based primarily on identifying individuals with heightened risk nearing the precipice of death, these initiatives face fundamental obstacles that cannot be overcome readily.

Objective This paper describes the step-by-step development of a comprehensive public health approach that seeks to integrate at the community level an array of programmatic efforts, which address upstream (distal) risk factors to alter life trajectories while also involving health systems and clinical providers who care for vulnerable, distressed individuals, many of whom have attempted suicide.

Conclusion Preventing suicide and related self-injury morbidity and mortality, and their antecedents, will require a systemic approach that builds on a societal commitment to save lives and collective actions that bring together diverse communities, service organisations, healthcare providers and governmental agencies and political leaders. This will require frank, data-based appraisals of burden that drive planning, programme development and implementation, rigorous evaluation and a willingness to try-fail-and-try-again until the tide has been turned.

THE PROBLEM

Suicide rates in the 21st century continue to rise in the USA despite the efforts of many states and localities; the formation of the National Action Alliance for Suicide Prevention, a public–private partnership and its publication of a second-generation national strategic plan in 2012[1]; the initiatives undertaken by the US Departments of Health and Human Services, of Veterans Affairs and of Defense; the deep commitment of many non-governmental organisations, family members of persons who had killed themselves and attempt survivors; and new research into the causes of suicide and the development and dissemination of 'evidence-based' approaches to intervention and prevention. Suicides increased from 29 350 during 2000, in a population greater than 282 million, to 44 193 during 2015 from among more than 321 million; rates per 100 000 changed from 10.40 (2000 base year) to 13.75 (13.26, age-adjusted).[2] They grew from 17.67 among men and 3.95 among women to 21.48 (21.00, age-adjusted) for men and 6.25 (6.04, age-adjusted) for women. The rise in suicide rates was driven especially by men and women in the 'middle years' of life, 35–64 years old, where there was an increase of 35.3% (13.9–18.8 per 100 000) from 2000 to 2015. Except for men 75 years and older, no age group showed a decrease.

While reducing suicide rates in the USA remains a knotty, vexing problem, it is a winnable battle.[3] Evidence regarding the effectiveness of initiatives to promote means safety,[4 5] as well as other specific methods of prevention,[5] has been accumulating. However, there are scant data to suggest that any single approach will have a substantial impact on reducing rates.[5] The US Air Force implemented a coordinated strategy involving multiple initiatives simultaneously,[6 7] but no such comprehensive, integrated efforts that embrace all ages, sexes and identified vulnerable populations, as well as incorporating local community priorities, have been undertaken to date by any state or region in the USA. This paper will lay out a series of tasks that comprise what would be involved in such an effort, illustrating them in part based on our developing experience in Colorado, a state that has set a goal for reducing suicides by 20% by 2024.

In addition to past tendencies to implement one-by-one interventions rather than a group of interlaced programmes that constitute a mosaic of actions,[8] there are inherent barriers to effective prevention,[9] especially as programmes have focused on seeking to detect persons at high risk as they enter perisuicidal periods and approach the precipice of death. These include: an inability to discriminate the relatively few true cases from the large number of false positive cases, that is, the preponderance of persons suffering severe psychological distress with diagnosed psychiatric disorders who, even while suicidal, neither attempt nor die by suicide; the large number of false-negative cases that escape preventive detection, that is, persons who seemed 'normal' but killed themselves or whose long-standing condition appeared no worse to family, friends or providers during the days immediately before their death; the inability of clinical and social services to reach many individuals who have serious suicidal intent; a continuing paucity of knowledge about fundamental biological, psychological, social and cultural factors that contribute to fatal suicide attempts among diverse populations and groups who have been labelled at-risk; and the lack of coordinated strategies for suicide prevention that can deal effectively with myriad local, regional, state and national agencies and organisations that could, in theory, play a role in preventing suicide. By exclusively seeking to identify highly vulnerable individuals at times of crisis, past efforts have not looked upstream to discern distal common risk factors that underpin multiple aetiologically related

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forms of premature death, including suicide, deaths from drug self-intoxication and deaths from risk-related medical disorders.[10] Upstream prevention efforts reach beyond perisuicidal periods to times when no suicidal thinking or behaviours may be apparent; while this may not seem to be suicide prevention to some observers because vulnerable persons have yet to reach symptomatic states, efforts to prevent fatal cardiac events or challenging-to-treat cancers often begin decades before their apparent onset with efforts to stop smoking, reduce high blood pressure and promote a healthy lifestyle. Added to these challenges, past prevention efforts understandably have tended to reflect the priorities of focused interest groups that have driven agendas based on their personal experiences rather than assessing the greatest potential contributions to reducing the collective suicide burden.[8] The challenge now for the field is to build partnerships encompassing a broader range of interest groups to foster priority settings across the prevention spectrum. This includes establishing buy-in from both traditional and non-traditional partners in public health, including those implementing violence prevention, substance abuse prevention, healthcare, criminal justice and child welfare, and employers as well as members of the workforce.

This paper does not focus on a conceptual discussion that emphasises the contextual nature of suicide, attempted suicide and other risk-related adverse outcomes (see ref 8). Rather, we highlight practical steps necessary to initiate, develop, implement and evaluate a community-based, systemic strategy that integrates the efforts of diverse stakeholders and approaches to build comprehensive, sustained, state-wide public health prevention programmes that engage diverse populations.

With this framework in mind, colleagues from the CDC-funded Injury Control Research Center for Suicide Prevention began working with leadership and staff from the Colorado Department of Public Health and Environment (CDPHE) to develop a systemic (far reaching, all-inclusive) approach to prevention that would cover the entire age range, with the intent of focusing on broad populations of highest burden while also attending to the specific needs of especially vulnerable groups. The goal has been to develop a comprehensive, upstream–downstream approach to prevention that combines tailored community-level efforts with those of established health systems, where the latter addresses the needs of highly vulnerable or severely distressed persons, appreciating that 'community' may involve populations that share common characteristics as well as geographically defined localities.

Why Colorado? It ranks among the leading states in terms of relative suicide burden, with 1093 suicides in 2015 among a population of nearly 5.5 million—the ninth highest rate in the USA at 20.0 per 100 000 residents. Colorado sits amid the western mountain states where suicide rates are highest nationally. Most important, there have been abiding commitments shown by the state's political and community leaders, with roots reaching back to the 1950s. They established the Suicide Prevention Commission and funded the Office of Suicide Prevention (OSP) as part of the CDPHE. Colorado already had begun several important initiatives by 2015 when we initiated our collaborative discussions and shared a philosophy that public health approaches to prevention should embrace multiple community and health system resources, with a recognition of the importance of a common risk model and the need for context-embedded approaches to preventing premature death from suicide and other risk-related causes, such as fatal drug intoxication.[8]

FIRST STEPS

Like other collaborative partnership processes, efforts to prevent suicide, attempted suicide and risk-related adverse outcomes depend on building trust, sharing perspectives, defining common goals and objectives and understanding areas of potential disagreement. Our process has developed in a fashion consistent with the guiding principles recently published by the National Action Alliance for Suicide Prevention (NAASP).[11] These include: unity: attainment and maintenance of broad-based momentum around a shared vision; planning: use of a strategic planning process that lays out stakeholder roles and intended outcomes; integration: use of multiple, integrated suicide prevention strategies; fit: alignment of activities with context, culture and readiness; communication: clear, open and consistent communication; data: use of surveillance and evaluation data to guide action, assess progress and make changes; and sustainability: a focus on long-lasting change.

In 2015, a team of national-level researchers and Colorado prevention leadership identified a shared goal of reducing suicide by 20% by 2024 through a collaborative research-practice model. Because strong leadership and group efficiency have been shown to improve implementation of collaboratively run prevention initiatives,[12] the team founded a formal structure—the Colorado National Collaborative (CNC). CNC developers strategically approached local and national stakeholders with diverse public health expertise for participation in the CNC. This included upstream prevention practitioners, mental health treatment providers, state and local government representatives, hospital association representatives, local and national suicide prevention researchers and evaluators and other stakeholders in suicide prevention (see figure 1).

As early team functioning is a critical indicator for future sustainability of collaborative efforts,[13] invited participants were brought together repeatedly and consistently, in person and virtually, to solidify a shared vision and identify the unique role that each sector representative might play. Assuring the centrality of state and local leaders rather than external academics, the CNC developed a clarified governance structure; it serves as a collaborating element to the Colorado Office of Suicide Prevention. The latter houses the coordinating centre for developing activities and, in turn, is accountable to the Governor's Health Cabinet (see figure 1). As the CNC has grown, membership has evolved. Drawing on the NAASP principles of unity and planning, CNC members regularly review the list of active local and national members to explore gaps in sector representation.

Diverse CNC membership is critical to ensuring that stakeholders from a broad range of community sectors have an opportunity to express their unique perspectives and priorities.

The CNC moved from a general discussion of principles—based on a collective vision of developing fundamental systemic changes[14] to exploring the geospatial distribution of burden 'centers' and county-level burden drivers, based on the efforts of CDPHE epidemiology staff using 2010–2015 data collected for the National Violent Death Reporting System (NVDRS). These allow an in-depth appraisal of local variations of suicide and differential geospatial expression of contributing factors to diverse-distinctive subgroups, as well as assessing changing patterns over time. This is being coupled with an ongoing state-level and community-level inventory of prevention efforts, broadly defined, that is collecting data from state agencies, non-governmental and voluntary agencies and health systems. Taken together with NVDRS data, it becomes possible to identify those populations that are covered by preventive interventions

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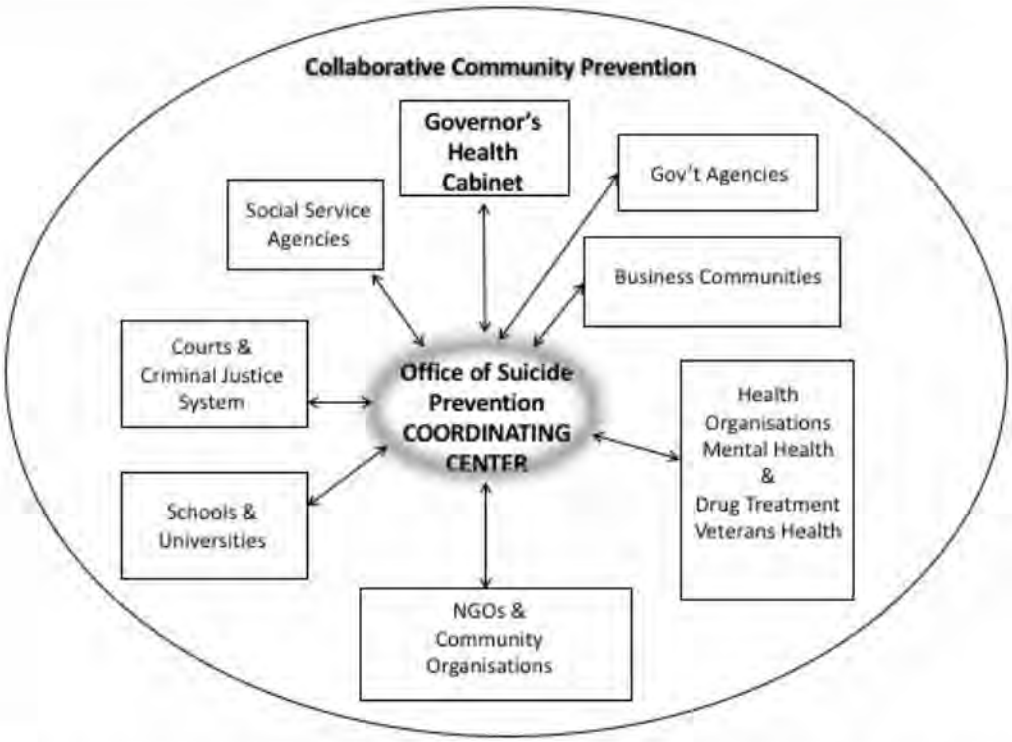


Figure 1 Governance structure for Colorado National Collaborative. NGO, non-governmental organisation; OSP, Office of Suicide Prevention.

and those that are missed—shining a light on gaps—an essential step when developing an adaptable strategy to reduce overall burden. Drawing on the NAASP guiding principle of using data for planning, these methods offer local community leaders inspection of home town data rather than a mash of less-specific state or national level statistics, allowing further identification of any missing local prevention programmes and collaborative consideration of programmes that best fit local needs.

WHO, WHERE AND WHAT

When working with communities and diverse potential stakeholders, it is especially useful to have a framework for defining who, where and what preventions to propose. The first grows from available data regarding those populations that contribute most to burden, as noted above, which naturally leads to a consideration of what to do and where to do it.[8]

Every community setting (eg, schools, workplaces, medical providers, the courts and residential settings) are part of an overall local fabric—a local social geography—where one can describe each site in terms of its sample bias, that is, the populations or groups that may be engaged and those that will be missed. Each sample bias must be considered when developing a comprehensive strategy that offers the potential of engaging groups and persons of interest. For example, schools and universities are settings for prevention efforts that offer access to a broad array of youth and young adults. Yet, they exclude those who have dropped out—especially, those who are vulnerable by dint of their drug use or legal problems—or who have joined the workforce. Primary care providers often are chosen to offer preventive interventions; while this may be well suited for elders who see their physicians at regular intervals, many men in the middle years of life do not participate in regular medical care.

Complementary to social geography, it is possible to track especially vulnerable individuals and groups through localities to determine the settings (including those using social media) where they may be encountered, that is, defining the social ecology for distinctive groups that have been exposed to social, family and personal adversities that may impart heightened levels of risk. By combining an understanding of social geography and social ecology, it becomes possible to start building the spatial foundation for a community-level strategy to reach those identified in the NVDRS-derived picture of local suicide burden.

Suicidal behaviour and interpersonal violence have been considered within a social-ecological framework.[8 15] Used to organise the myriad factors that contribute to violent behaviour, this framework also can be used to clarify the level of action of protective factors and guide the development of interventions at individual, relationship, community and societal levels (see figure 2). The challenge that ensues relates to defining which interventions to emphasise and in which settings to deploy them for the general population and for those of special interest.

The Suicide Prevention Resource Center maintains guidance for 'evidence based' interventions (www.sprc.org/search/evidence/based/intervention). This, however, does not define how one might best integrate this diverse array of interventions into a comprehensive, integrated set of programmes that reach across the entire age range. The LifeSpan programme (http://www.lifespan.org.au) in New South Wales, Australia, has begun to implement a systems model much like the one being developed in Colorado that seeks to build an integrated approach to prevention. LifeSpan has identified nine overlapping elements: aftercare and crisis services; psychosocial and pharmacological treatments; guidance and support of primary care providers; training frontline staff; gatekeeper training; schools programmes; community campaigns; media guidelines; and means restriction. This effort gives major attention to 'what' and indications of 'who' and 'where'.

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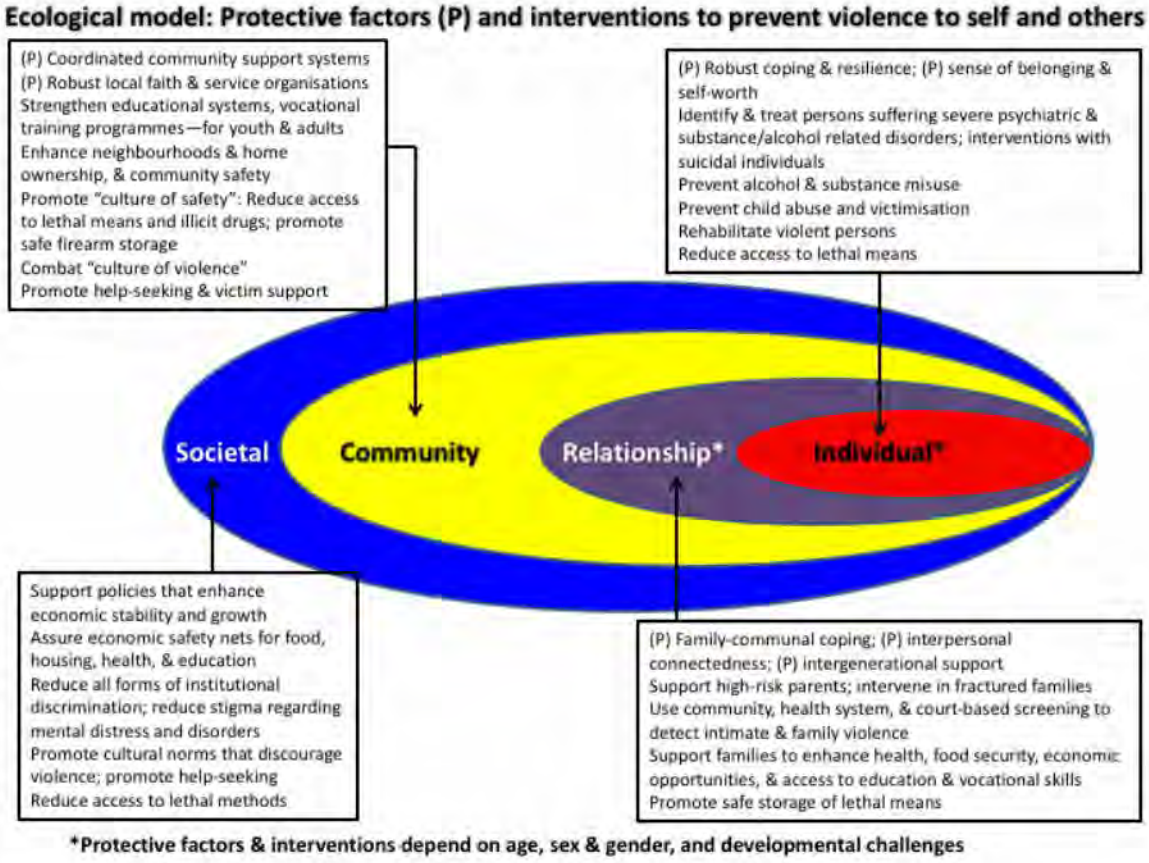


Figure 2 Socioecological model for protective factors and interventions to prevent violence to self and others.

Similar to the LifeSpan programme, Stone and colleagues at the CDC National Center for Injury Prevention and Control recently promulgated a technical report on strategies and related approaches to prevention—considered within an ecological framework—that offer evidence of positive impact.[16] They focus on seven basic strategies: strengthening economic supports; strengthening access and delivery of 'suicide care'; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at risk; and lessening harms and preventing future risk.

By integrating data regarding suicide burden defined by age, sex and other demographic features, together with local information regarding social geography and the social ecology pertaining to groups of interest, one can create 'maps' that can serve as a basis for establishing age-specific deployment of preventive interventions, as illustrated in figures 3–5. These maps depict where communities need to focus when deploying preventative interventions. Circles relate to settings conducive to engaging populations of interest with intersections arising from individual mobility; bold lettering emphasises the importance of programme development in specific areas where it is more likely to encounter either larger (although with lower rates) or potentially important groups; and capital letters are indicative of settings likely to present a higher percentage of higher risk groups and individuals. Fundamental to this approach is the recognition that prevention efforts are diverse yet potentially specific depending on the demographic and social features of targeted populations—in terms of time, space and what will be needed to respond to the extraordinary heterogeneity among those who kill themselves. The maps underscore that the settings suitable for one age group—or for subgroups each having a different social ecology,—will differ from another and point to the fundamental need for developing community-integrated prevention offerings.

Bringing process and content together, the goal is to 'place' evidence-based and best-bet preventive interventions with the contexts that comprise what we call 'communities', appreciating that communities are recognised as the basis of their common interests and life experiences, as well as their geospatial distributions.[17] They potentially will have different components or areas of emphasis depending on age, sex, sexual orientation and gender identification, cultural make-up, economic factors, health status and identified population-level risks, the latter being arrayed in a social-ecological framework.[8] Interventions such as the development of means safety programmes reach across communities and depend on the involvement of selected participants (eg, gun shop retailers, pharmacists, urban planners and architects designing buildings and public spaces); others, such as the careful individual tracking of persons who have attempted suicide, benefit from alliances between health and mental health providers and, ideally, family and community partners. It is foreseeable that individual-level programmes that use 'big data' and algorithm identification of especially vulnerable individuals can be embedded into systems of care that are comprehensive, far-reaching and linked with computer-assisted communication tools. Dispersed groups or those who may be hidden in the face of social pressure and apparent stigma (eg, LBGTQ youth and young adults; adult men in need of mental health services) may be reached via social media and other niche marketing approaches. In sum, the extraordinary geographical, cultural and ethnic and racial diversity of the USA requires that, to be effective, preventive interventions will require careful consideration of the NAASP principle

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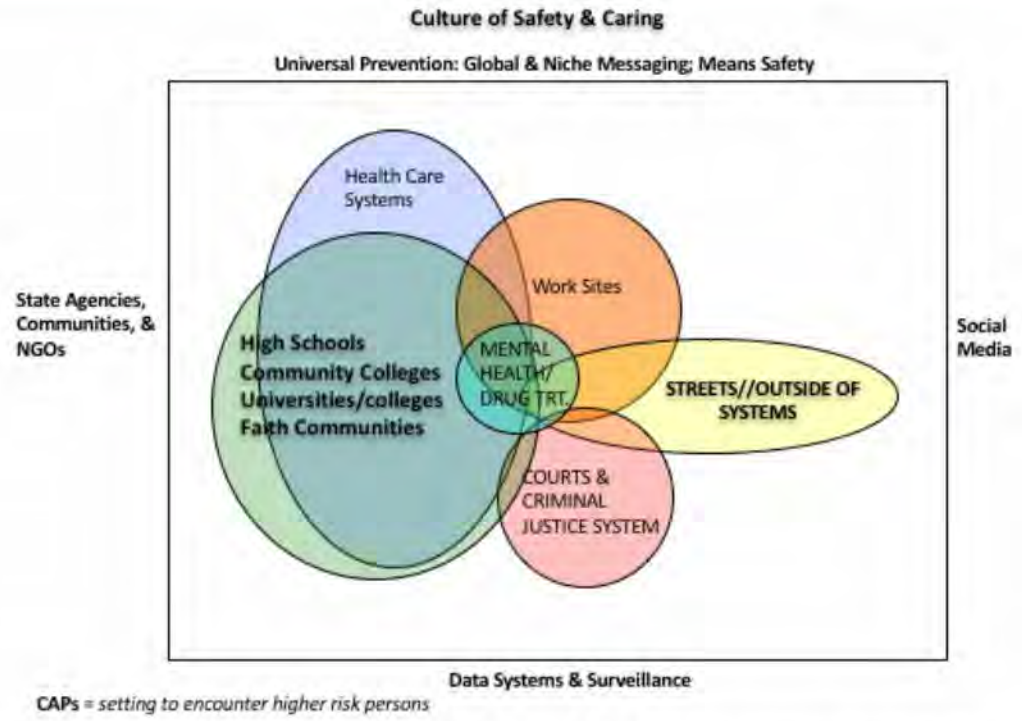


Figure 3 Settings for collaborative community prevention for youth and young adults. NGOs, non-governmental organisations.

of fit: alignment of activities with context, culture and readiness. Careful tailoring of preventative interventions will be based on collaborative discussions that address the challenges of time, place, group and individual differences. While top-down leadership and commitment is essential, effective actions necessarily will be ground level—locally energised, developed and owned.

Recognition of such ground-level efforts may require movement from strict adherence to research-based empiricism to the complementary paradigm of 'community-based empiricism' and leadership. Practice-based evidence looks to resolve the tension between evidence-based prevention and locally grown efforts by recognising that effective programmes and practices can and do emerge from community expertise.[18] Such tensions can be further resolved by a commitment from the CNC to building the evaluation capacity of communities to evaluate home-grown efforts. Valuing community-derived experiences

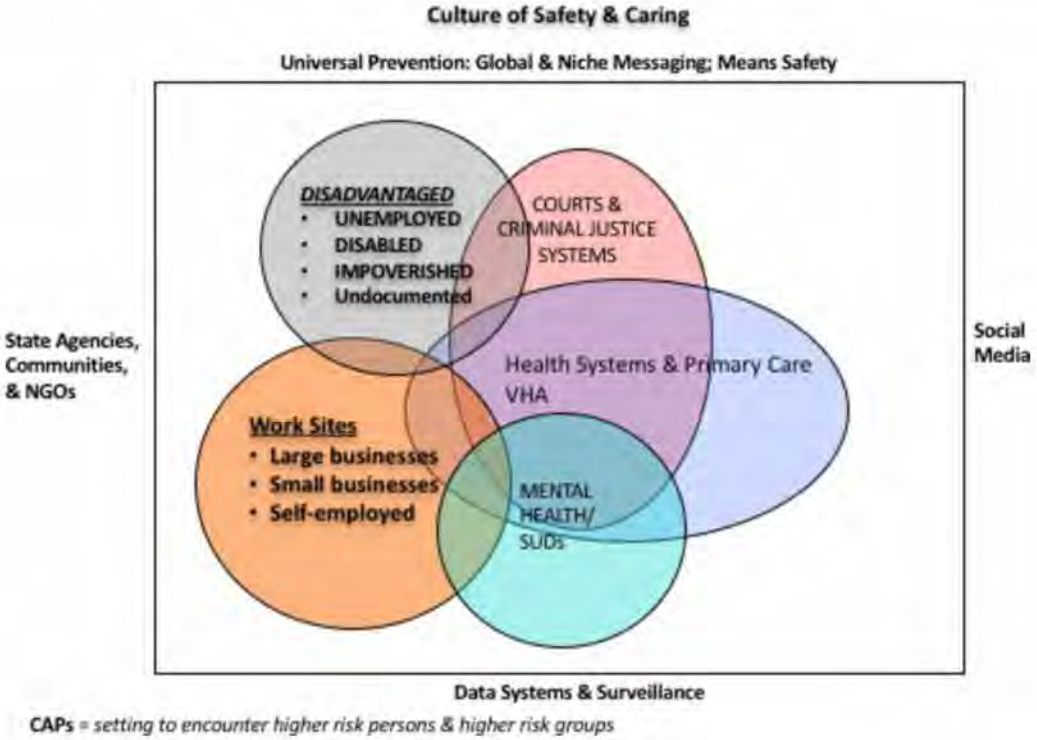


Figure 4 Settings for collaborative community prevention for adults. NGOs, non-governmental organisations.

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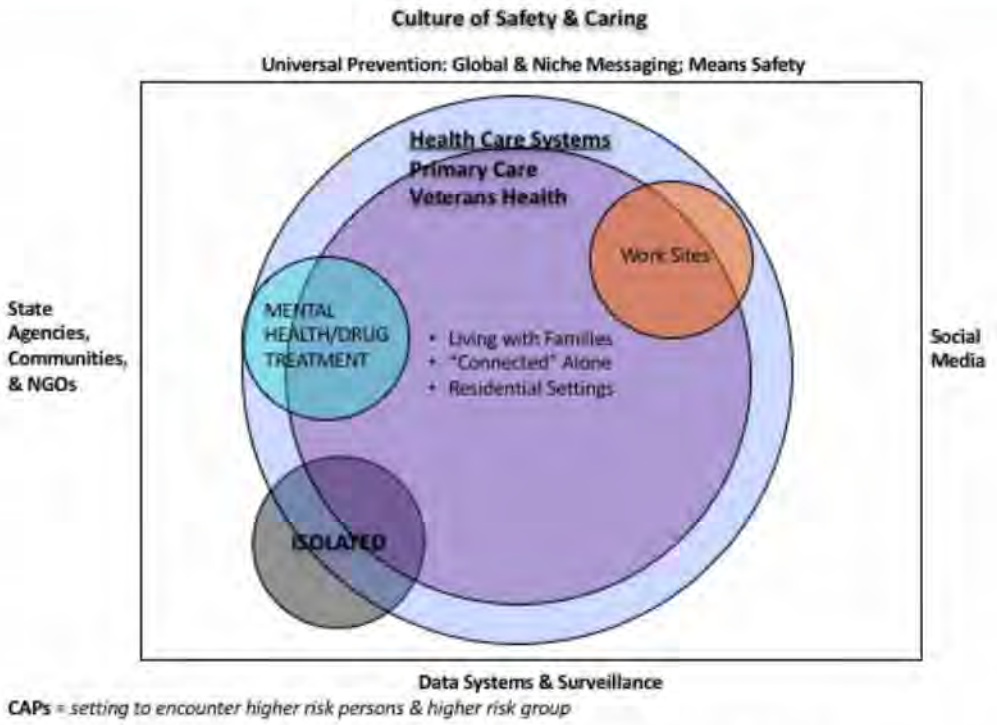


Figure 5 Settings for collaborative community prevention for elders. NGOs, non-governmental organisations.

also has the potential to reinforce local commitment and sustained efforts.

IMPLEMENTATION AND EVALUATION

Moving from talk to action poses multiple challenges. To name a few: implement programme elements all-at-once versus a stepwise process; implement programme elements in all target regions or selectively at first; emphasise the evaluation of process indices (eg, training-related evaluations), impact metrics (eg, practice and access to care) changes or ultimate outcome measures (eg, fewer attempts and deaths); define 'long enough' to assess meaningful impact; and assure longer term sustainability. Process metrics can be useful for measuring the development of community coalitions, but they do not provide data regarding changes in practice. They are less expensive to deploy and may be useful during start-up phases. They help ascertain what programme implementers are learning and how they are navigating the challenges of building necessary local prevention fabric. Impact measures do not offer a conclusive sense that programmes are 'working', yet they can serve as indices of continuous quality improvement, which are central to improving health service delivery and useful as a way of monitoring engagement of target populations. Outcome data reveal whether lives were saved. Communities and advocates understandably want to move quickly and mount all-out efforts to save lives; however, researchers and advocates of rigorous programme evaluation may warn against hasty action, understanding that many efforts that seem to have had 'face validity' have failed.[8]

When the US Air Force began to implement its multifaceted suicide prevention programme in 1996–1997, it had not established an evaluation strategy. The retrospective approach that eventually was used hypothesised that, given its emphasis on upstream factors that apparently contributed to increasing risk for multiple adversities (a common risk strategy), the programme's impact would influence multiple risk-related outcomes (ie, suicide, accidental death, homicide and family violence).[6] When suicide rates climbed in 2004, a retrospective examination of programme and policy implementation allowed for a second level of hypothesis-driven analyses.[7]

While revealing, this type of implementation–evaluation approach is less satisfactory than prospective designs. Mindful of proponents' urgency for implementing initiatives, NOW! researchers have been developing novel designs that seek to measure the effects of multiple evidence-based interventions at the same time while measuring overall impact. These methods take advantage of spatial diversity, understanding that there typically is insufficient capacity to implement all actions in all places instantaneously, and benefit from limited training capacity, recognising that most often it is not possible to train at once all programme implementers to high levels of programme fidelity.[19 20] Another methodology that may assist with these efforts involves system dynamics modelling as a way of conceptualising the dynamic forces influencing suicide, attempted suicide and risk-related premature deaths.[21]

When implementing a comprehensive set of initiatives, including both upstream (distal) and downstream (more proximal) intervention efforts to address the needs of acutely distressed individuals, it will be possible to examine outcomes that are socially and clinically important, even as they may be 'outside' the immediate realm of suicide and suicide-related thoughts or behaviours. The US Air Force programme emphasised early interventions to stem the severity of family violence, even as it sought to reduce suicides. Thus, it was possible to test for a hypothesised increase in the frequency of mild family violence coupled with a decrease in moderate and severe violence—itself a positive outcome.[6] Similarly, there are multiple interventions for youth, adults and elders that can yield quantitatively defined, personally and socially meaningful 'intermediate' beneficial results, arrayed along a hypothesised set of pathways-to-suicide. These types of predefined outcome

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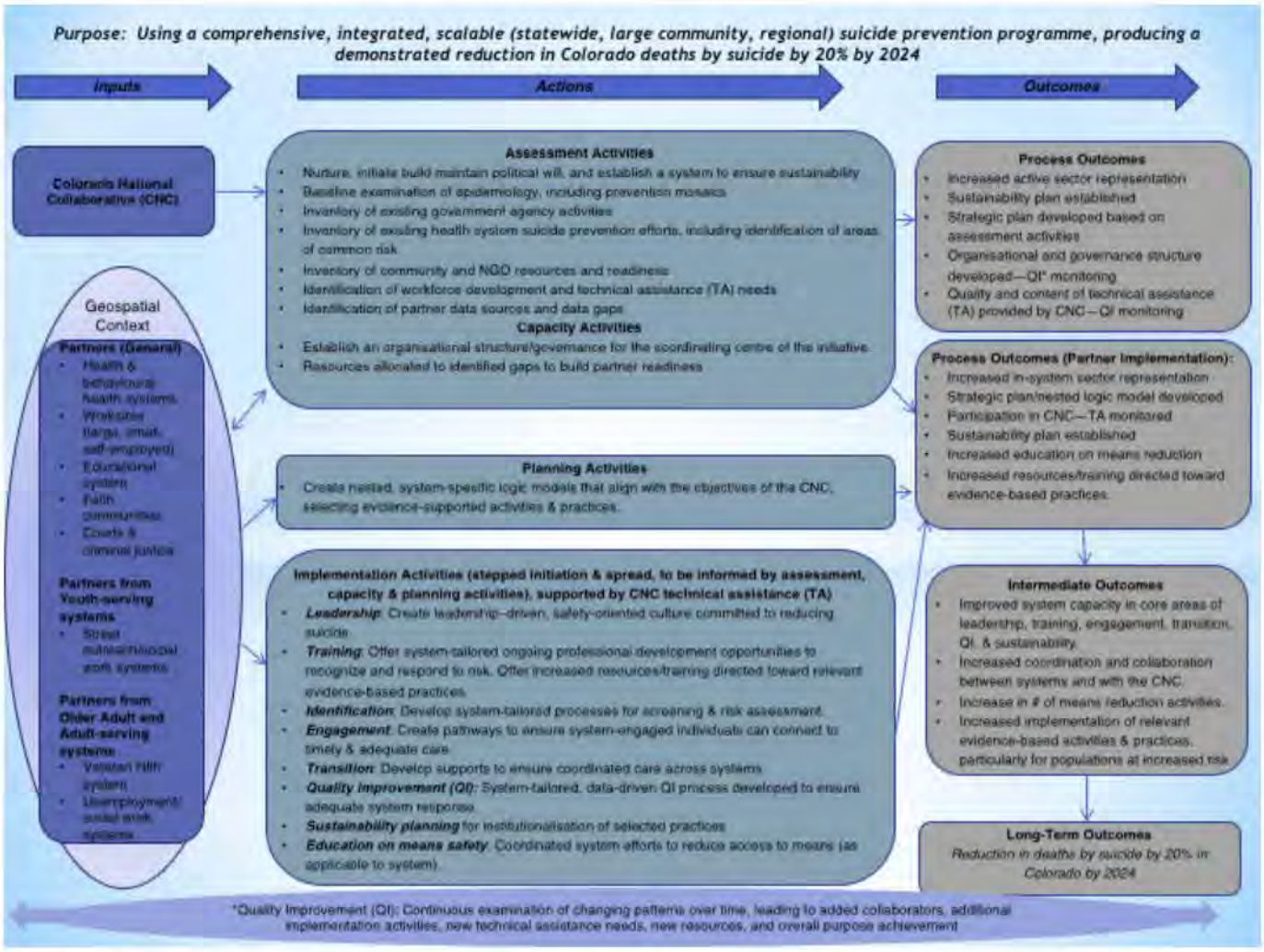


Figure 6 A logic model for implementing comprehensive integrated suicide prevention.

metrics can provide confidence that programmes are building the desired impact long before more distal outcomes—declining rates of suicide attempts and suicides—can be measured consistently year over year. To bring these many action steps into a more cohesive format, the CNC developed a logic model to organise its efforts (see figure 6). This outlines the paths that we are taking to implement our efforts in a coherent and transparent fashion.

CONCLUSION

Suicide prevention efforts have tended to be one-by-one initiatives rather than comprehensive efforts that bring together communities, state agencies, health systems and diverse stakeholders to work in a synergistic fashion that pushes forward multiple efforts simultaneously. Suicide is not a singular problem, or a specific medical diagnosis. Rather it serves as a final common pathway for an array of elements reflecting personal, family, community and societal stresses and turmoil—typically expressed one individual at a time. While the final moments of action—killing oneself—predominantly have drawn past attention from medical and mental health professionals, it is timely to integrate the person level with what can be done in both health systems and beyond their walls across entire communities, and far upstream, so that it is possible to alter life trajectories.

Such efforts require leadership and sustained commitment, a willingness to partner with diverse groups, an openness to strict scrutiny and evaluation by others, the integrity to acknowledge failures as well as proclaim successes, a willingness to go beyond what is known with certainty and the realisation that drastically reducing the burden of suicide and risk-related premature deaths depends on fundamental social changes. While these efforts must be based on best evidence and conducted with scientific rigour, they ultimately depend on an unstinting courage of convictions that saving lives

What is already known on the subject

- To date, there have been no sustained, far-reaching state-level or regional suicide prevention programmes in the USA that comprehensively involve populations across the life span and combine community-driven initiatives with those of health systems and other potential partners.
- Most suicide prevention initiatives in the USA have focused on individuals deemed to have imminent risk.
- It has been very challenging to develop comprehensive public health suicide prevention programmes that integrate upstream (distal) and downstream (proximal) strategies.

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What this study adds

- Discusses practical steps for the development of a comprehensive, integrated community-driven suicide prevention programmes.
- Considers the barriers and opportunities for successfully implementing such efforts.

depends on a collective societal willingness to make a difference in the lives of profoundly vulnerable persons, families and communities.

Acknowledgements Thanks to colleagues in the Injury Control Research Center for Suicide Prevention, the Colorado Department of Public Health and Environment, the Colorado Suicide Prevention Commission and the Colorado National Collaborative.

Contributors All authors contributed to the planning of this paper and the developments described for the Colorado National Collaborative (CNC). The logic model was developed by KQ based on the discussions of the authors and colleagues. EDC drafted the paper and the remaining figures, which were reviewed and approved by all authors.

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Disclaimer The content is solely the responsibility of the authors and does not necessarily represent the official views of CDC.

Competing interests None declared.

Provenance and peer review Commissioned; externally peer reviewed.

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Comprehensive, integrated approaches to suicide prevention: practical guidance

Eric D Caine, Jerry Reed, Jarrod Hindman and Kristen Quinlan

Inj Prev published online December 20, 2017

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What is the Colorado-National Collaborative (CNC)?

Goals and Tasks

The goal of the CNC is to create a comprehensive suicide prevention model to reduce suicide statewide by 20% by 2024. Through careful evaluation, the CNC also aims to become a model for other states.

The CNC's tasks include:

This is really a groundbreaking endeavor and a very important proof of concept to show that suicide prevention is possible using a data driven, public health approach envisioned by Surgeon General Satcher in his 1999 call to Action.

- Assessment:
  - Identify counties experiencing the highest numbers and rates of suicide and, in those counties, work to plan prevention efforts. This will involve learning more about the characteristics of people dying by, attempting or contemplating suicide including demographic information (e.g., age, race, marital status), the method used in suicide deaths and attempts, and information about the circumstances surrounding suicide deaths. This information is available through Colorado's Department of Public Health and the Environment, and can be found by clicking here.

    Six counties selected.
  - Work with those counties experiencing the highest numbers and rates of suicide to identify existing prevention initiatives, available resources, existing gaps, and interest in supporting new and enhanced efforts.

    An inventory sent out assessing existing county resources and service related to suicide prevention.
  - Inventory existing data and identify gaps in what we know about the problem to help identify the best solutions.

    Meetings with three counties held so far to talk about the initiative and to show counties where the burden of suicide exists in their county, e.g. what populations have the highest risk. Essentially the counties learned that youth suicide prevention, while valuable is not where the highest need is. Need to look to middle aged.
- Capacity Building:
  - Engage partners from diverse systems and settings (e.g., public health, social services, workplaces) that serve individuals and communities at risk, with initial focus on engaging leaders from counties experiencing the highest numbers and rates of suicide.

    These initial conversations have begun. ditto for next bullet. Alex and shakiyla participated in the above meetings in CO in dec'17
  - Work with newly-engaged partners to identify how they can contribute to and benefit from the CNC's efforts.
  - Strengthen public awareness and professional education to build suicide prevention capacity.

    This is something planned for the future.
- Planning:
  - Build on and enhance prevention efforts within health care and community-based settings using a range of evidence-based policies, programs and practices to prevent risk before it occurs and to identify and support people at risk.
  - Facilitate and strengthen coordinated and comprehensive suicide prevention action plans across communities, systems and settings.

    The Colorado National Collaborative is still very much in its planning phase. Limited resources available at this point. CDCF is looking for donors. AFSP has already given at least $200k to CODPHE. This was outside the foundation, fyi. It would be great if we can emphasize the value of the CDCF
- Implementation:
  - Implement coordinated action plans to ensure cost-effective and sustainable change.

    May be good to reinforce that CDCF is a valued asset. So far we haven't seen evidence of this yet so i think there may be some skepticism among the collaborative.
- Evaluation:
  - Systematically evaluate progress and outcomes in order to support continual improvement, demonstrate success, and allow Colorado to serve as a model for other states.

    ICRC-S is hosting a meeting in rochester on 5/7 to continue conversations related to the best approaches for implementation and evaluation of the comprehensive approach envisioned.

Background and History

Colorado's suicide rate, 20.30 per 100,000 in 2016[1], is among the highest in the nation.[2] Solutions to complex public health problems, like suicide, are often most successful when government, businesses, health services, nonprofit organizations, and individual citizens coordinate their efforts. This way, partners can channel their resources to the same goals, avoid duplicating efforts, and enhance each other's work to produce lasting change.

The Colorado-National Collaborative (CNC) is a partnership of scientists and public health professionals working with health and social service agencies, nonprofit organizations, government agencies, businesses, academic organizations, and Colorado residents to identify, promote and implement successful state- and community-based strategies for suicide prevention in Colorado.

Current CNC partners include:

National Partners:

- Centers for Disease Control and Prevention's Injury Control Research Center for Suicide Prevention (ICRC-S)
- Centers for Disease Control and Prevention's National Center for Injury Prevention and Control
- National Action Alliance for Suicide Prevention
- Substance Abuse and Mental Health Services Administration's (SAMHSA) Suicide Prevention Resource Center
- American Foundation for Suicide Prevention

Local Partners:

- Colorado Department of Public Health and Environment (CDPHE)
- Colorado's Suicide Prevention Commission
- Rocky Mountain Mental Illness Research, Education and Clinical Center at the Denver Veterans Administration Medical Center
- Governor's Office
- Colorado Behavioral Healthcare Council
- Colorado School of Public Health
- University of Colorado Depression Center

[1] Vital Statistics Program, Colorado Department of Public Health and Environment
[2] Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WISQARS Online Database

For more information contact Jarrod Hindman, MS, Deputy Chief of Violence and Injury Prevention in the Mental Health Promotion Branch of Colorado's Department of Public Health and the Environment, at jarrod.hindman@state.co.us.

Information on Colorado's Suicide Prevention Efforts and resources can be found by clicking here.



From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 1 Jun 2018 16:54:51 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Question
Attachments: NVDRS Call June 5.docx

Deb –Here are draft talking points for the NVDRS call on Tuesday. They're high-level overview of the Vital Signs data and logistics.
I think there should be a way to figure out how to share with them verbally the map in the fact sheet – I don't know what that would sound like but maybe you do?
Wanted to get these to you to review – but I think I will tweak on Monday as well.
Malia

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 9:06 AM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Subject: RE: Question

Sounds good. Thanks so much!
Deb

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Friday, June 1, 2018 9:05 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: Question

I'll pull something together and share with you today. It will basically be: overview of findings, the timeline for release, that they will receive the embargoed copies and when, and what support we might be able give them to help answer questions from their SHOs, media etc.
Let's talk in person on Monday about what else we might be able to share on the phone.
Malia

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 31, 2018 8:07 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Subject: RE: Question

Hi Malia,
I'm happy to join. Would be helpful to have a general outline of what I might want to say. I can then create the talking points from there. Is that possible?
Thanks,
Deb

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 31, 2018 7:38 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Subject: Re: Question

Hi Deb - It is still on, it's June 5 at2pm. do you want to join? since we won't be able to share findings in the 5th I was treating it as a partner call to prime them for the release. It would be great if you have time. It would only be the first 10-15 mind of the call.
Malia

From: "Stone, Deborah (CDC/ONDIEH/NCIPC)" <zaf9@cdc.gov>
Sent: Thursday, May 31, 2018 5:58 PM
To: "Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)" <gdo4@cdc.gov>,"Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)" <jrv8@cdc.gov>
Subject: Question

Hi Shane and Malia,
Is the NVDRS call with states still on to discuss Vital Signs? Do you need me to do this?
Didn't want to lose track of this.
Thanks!
Deb

Deb Stone, ScD, MSW, MPH
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National Center for Injury Prevention and Control
Division of Violence Prevention
Suicide, Youth Violence & Elder Maltreatment Team
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CDC's Injury Center
Preventing Injuries and Violence
Through Science and Action

NVDRS Call – June 5

Talking points

CDC will release a Vital Signs on June 7 that examines rising suicide rates across the United States.

- For this *Vital Signs* report, CDC researchers examined state-level trends in suicide rates from 1999-2016. Additionally, 2015 data from CDC's National Violent Death Reporting System, which covered 27 states, was used to look at the circumstances of suicide among people with and without known mental health problems

- Nearly 45,000 lives lost to suicide in 2016.

- Across the study period, rates increased in all states except for one (which had a consistently high rate throughout). Twenty-five states had suicide rate increases of more than 30 percent.

- More than half of people who died by suicide did not have a known mental health condition.

- The Vital Signs points to ways that states take a comprehensive public health approach to suicide prevention and address the range of factors contributing to suicide.

    - This requires coordination and cooperation among a wide variety of community partners.

    - CDC's technical package on suicide prevention can help states as they make decisions about prevention activities and priorities.

NVDRS Directors will receive an embargoed copy of the Vital Signs at 9am on June 7. State Health Officers will receive this information at 9am as well. As will the media

Vital Signs will be released publically at Noon on June 5 with a telebriefing hosted by Dr. Ann Schuchat, CDC Deputy Director

NCIPC and DVP social media channels will be disseminating information about Vital Signs from June 7-June 19 – including a Twitter Chat on June 11 at 2pm

There will be a Vital Signs Town Hall on June 12 from 2-3pm, which will feature both CDC and state health department speakers

From: Marshall, Khiya J. (CDC/ONDIEH/NCIPC)
Sent: 4 Jan 2018 08:44:05 -0500
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Girod, Candace (CDC/ONDIEH/NCIPC)
Subject: RE: Reminder/Handouts to print for Environmental Scan Survey Review

That's great! ☺

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, January 04, 2018 8:42 AM
To: Marshall, Khiya J. (CDC/ONDIEH/NCIPC) ; Girod, Candace (CDC/ONDIEH/NCIPC)
Subject: RE: Reminder/Handouts to print for Environmental Scan Survey Review

Thanks, Khiya. Candace has been so helpful!!

From: Marshall, Khiya J. (CDC/ONDIEH/NCIPC)
Sent: Thursday, January 4, 2018 8:41 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Girod, Candace (CDC/ONDIEH/NCIPC) <mrv7@cdc.gov>
Subject: RE: Reminder/Handouts to print for Environmental Scan Survey Review

Hi Deb,
I spoke with Candace and she provided an update. Since the two TP questions need to be modified, I'll wait to provide any input. I know that Candace is going to follow-up with DARPI (thanks, Candace), but please let me know if you anything else.
Thanks,
Khiya

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, January 03, 2018 11:43 AM
To: Marshall, Khiya J. (CDC/ONDIEH/NCIPC) <fys7@cdc.gov>; Girod, Candace (CDC/ONDIEH/NCIPC) <mrv7@cdc.gov>
Subject: FW: Reminder/Handouts to print for Environmental Scan Survey Review

HI Ladies,
Happy New Year. I know this is last minute but I wanted to send you this meeting invite for today. Even if you can't attend I'd like to ask that you provide input on the technical package questions for our state of state suicide prevention environmental scan. I think you might have good advice on what to ask.
Thanks!
Deb

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 3 Jan 2018 17:19:44 +0000
To: Marshall, Khiya J. (CDC/ONDIEH/NCIPC);Girod, Candace (CDC/ONDIEH/NCIPC)
Subject: RE: Reminder/Handouts to print for Environmental Scan Survey Review

No problem, Khiya! And thanks. I'm so glad Candace can make it.
Deb

From: Marshall, Khiya J. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, January 3, 2018 12:18 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Girod, Candace (CDC/ONDIEH/NCIPC)
Subject: RE: Reminder/Handouts to print for Environmental Scan Survey Review

Hi Deb,
I'm working on two deadlines and will not be able to make the meeting. I will definitely take a look at the TP questions and provide feedback.
Thanks,
Khiya

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, January 03, 2018 11:43 AM
To: Marshall, Khiya J. (CDC/ONDIEH/NCIPC) <fys7@cdc.gov>; Girod, Candace (CDC/ONDIEH/NCIPC) <mrv7@cdc.gov>
Subject: FW: Reminder/Handouts to print for Environmental Scan Survey Review

HI Ladies,
Happy New Year. I know this is last minute but I wanted to send you this meeting invite for today. Even if you can't attend I'd like to ask that you provide input on the technical package questions for our state of state suicide prevention environmental scan. I think you might have good advice on what to ask.
Thanks!
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 31 May 2018 16:48:41 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Subject: RE: RE: June Vital Signs Did You Know factoids

I agree with pushing back. The TP is call to action in the VS so the factoids would be inconsistent without this.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 31, 2018 4:31 PM
To: Bruce, Crystal (CDC/OPHPR/OD) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: RE: June Vital Signs Did You Know factoids

Ok, that's what I figured it was but we don't have another call to action. Comprehensive prevention is our action and the technical package is our vehicle (not to mention call to action in the vital signs).
I think we need to push back.
Deb

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Thursday, May 31, 2018 3:50 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: RE: June Vital Signs Did You Know factoids

The issue is that the DYK in March used the technical package as a call to action. Diane at OSTLTS thinks her leadership won't like having the same call to action again so soon.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 31, 2018 3:47 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: RE: June Vital Signs Did You Know factoids

Is the issue that we can't say technical package or we can't link to the technical package. If it's the latter, I don't think there is an alternative! If it's the former we could say 'communities can work together to develop a comprehensive approach to suicide prevention based on the best available evidence .

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Thursday, May 31, 2018 3:35 PM
To: Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: FW: RE: June Vital Signs Did You Know factoids

Hello all,

If we cannot say to states and communities "use the technical package" as a call to action, what do you recommend?
Crystal

From: Hawkins-Cox, Diane K. (CDC/OSTLTS/OD) (CTR)
Sent: Thursday, May 31, 2018 3:29 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: RE: June Vital Signs Did You Know factoids

I think this would be ideal, assuming there will be links in the first two bullets (and pending comm leadership approval), but…
In March we had a DYK about teen suicide that used the same call to action:

- After declining from 1990 to 2007, suicide rates among teens aged 15–19 have been on the rise, doubling among females and increasing 31% among males.
- Suicidal behavior is complex and associated with multiple risk and protective factors, many of which are common in youth.
- Communities can help prevent suicide by using strategies based on best available evidence[PDF-6MB], working with suicide prevention organizations, and promoting information about lifelines for people in distress.

I suspect leadership will balk at promoting the same call to action within two months. Might you have any alternatives?

Diane

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Thursday, May 31, 2018 3:11 PM
To: Hawkins-Cox, Diane K. (CDC/OSTLTS/OD) (CTR) <jzo0@cdc.gov>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: RE: June Vital Signs Did You Know factoids

Thanks for the guidance and clarification, Diane!
This is our first Vital Signs and we are learning as we go! Here are my revised bullets, based on your recommendations:

- Nearly 45,000 lives lost to suicides in 2016.
- More than half of people who died by suicide did not have a known mental health condition.
- Communities can work to put in place a comprehensive suicide prevention program using CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*

Let me know if this will work…
Crystal

From: Hawkins-Cox, Diane K. (CDC/OSTLTS/OD) (CTR)
Sent: Thursday, May 31, 2018 2:42 PM
To: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: RE: June Vital Signs Did You Know factoids

Thanks much! But we need a call to action for our audience of state, tribal, local, and territorial health professionals. Not sure if you got the DYK writing guidelines, but the bullets generally follow this format:

Provide three bullets only:

- A timely news fact or data point
- The associated health impact and/or economic impact
- A call to action, such as
  - States and communities can prevent alcohol poisoning deaths by supporting proven programs and policies to reduce binge drinking.
  - You can help others improve their eating habits by promoting the Million Hearts® initiative's Healthy Eating & Lifestyle Resource Center.
  - Health departments can promote safe injection practices with this free healthcare provider toolkit.

So maybe the first bullet could combine your current first and third bullets, and the new bullet could promote some recommendation you want our audience to follow to tackle the problem. Does this make sense?

Diane

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Thursday, May 31, 2018 12:50 PM
To: Hawkins-Cox, Diane K. (CDC/OSTLTS/OD) (CTR) <jzo0@cdc.gov>
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: June Vital Signs Did You Know factoids
Importance: High

Hello Diane,

Please find our *DYK* bullets for the upcoming June *Vital Signs*, being released on June 7th. Let us know if you need more information or have any questions, and Thanks in advance.

- Nearly 45,000 lives lost to suicides in 2016.
- Suicide rates went up more than 30% in half of states since 1999.
- More than half of people who died by suicide did not have a known mental health condition.

Respectfully,

Crystal Bruce, MPH
Health Communications Specialist
Detailed to National Center of Injury Prevention and Control
Division of Violence Prevention, Health Communications Team
Office: 770-488-5651
Mobile: 470-249-3616
Cbruce2@cdc.gov
Off alternate Fridays

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 1 May 2018 15:12:13 -0400
To: Bruce, Crystal (CDC/OPHPR/OD)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Subject: RE: RE: Proposed talking points for SG at telebriefing

Agree with Malia's points. You could use some of the talking points from Alex's Medscape commentary as well. Thanks Crystal.

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 1, 2018 3:05 PM
To: Bruce, Crystal (CDC/OPHPR/OD) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: RE: Proposed talking points for SG at telebriefing

Hi Crystal – I think it might be a good idea to include some talking points that connect the Surgeon General to health care providers and what providers can do to prevent suicide. He's the "nation's doctor" so feels like this would be a good role for him on the telebriefing, also could tie in a talking point about physicians risk for suicide. I believe Deb mentioned this at the last Suicide Center briefing, this might be a way to integrate that feedback.

Healthcare systems can:

- Provide high quality, patient-centered, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in proven treatment options for patients who are at risk of suicide.

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Tuesday, May 1, 2018 2:17 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: Proposed talking points for SG at telebriefing

Hi all,

Based on today's meeting, here's the email and talking points I drafted to send up to the SG's office. Let me know if you think I'm on track with these, or not:

We had our Vital Signs workgroup meeting today and everyone thought it might be helpful if we proposed some talking points for Dr. Adams. I've pulled from the first part of the telebriefing script and here's what we propose:

- It's simply not acceptable that we are losing nearly 45,000 lives a year to suicide in this country, many of whom are military members or veterans.
- The tragedy of suicide demands a proactive and coordinated response, from all sectors in a community. We have been working with public and private partners to advance the National Strategy for Suicide Prevention.

- At the Federal level, we are tracking the problem of suicide and suicide attempts to better understand the trends and what groups at greatest risk.
- Today's report contains new information about rising suicide rates across the U.S. and highlights the range of factors contributing to suicide.
- The good news is there are opportunities to prevent suicide every day. Knowing the full range of factors contributing to suicide risk can help states and communities think more broadly about prevention opportunities.

Crystal Bruce, MPH
Health Communications Specialist
Detailed to National Center of Injury Prevention and Control
Division of Violence Prevention, Health Communications Team
Office: 770-488-5651
Mobile: 470-249-3616
Cbruce2@cdc.gov
Off alternate Fridays

Suicide rates rising across the US

More than a mental health problem

45,000

Nearly 45,000 lives lost in 2016



30%

Suicide rates increased more than 30% in half of states since 1999

50%

More than half of people who died by suicide did not have a known mental health problem

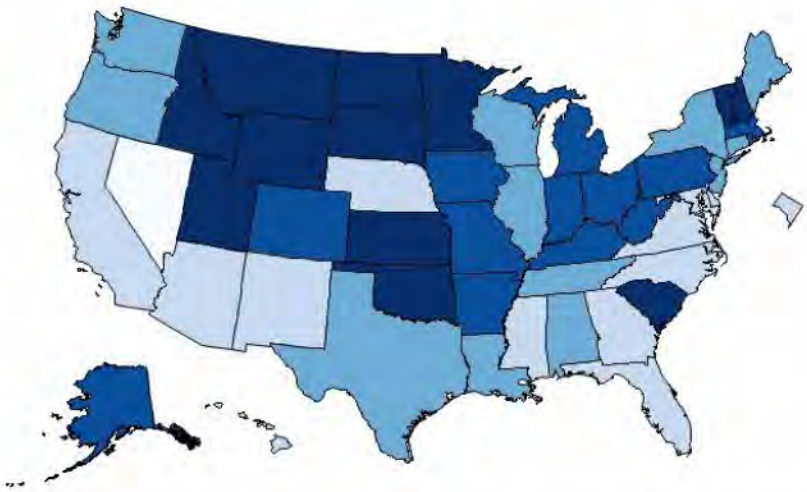
Suicide is a leading cause of death in the US and increased in nearly every state from 1999 through 2016. Although the reasons for the increases need more study, many factors are known to contribute to suicide. Mental health problems are often seen as the cause of suicide, but suicide is rarely caused by any single factor alone. In fact, many people who die by suicide are not known to have a diagnosed mental health problem at the time of death. Among people with or without mental health problems, other issues often contribute to suicide. These include relationship problems or loss, substance use problems, physical health concerns, and job, money, legal, or housing stress. Close coordination of government, public health, healthcare, business, and education sectors, along with media and community-based organizations, is important for preventing suicide. Public health departments can be leaders in bringing together these partners and guiding comprehensive efforts based on the best available evidence.

States and communities can:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Create safe and supportive environments, including securely storing medications and firearms to reduce access among people at risk.
- Connect people to others in their community so they don't feel alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

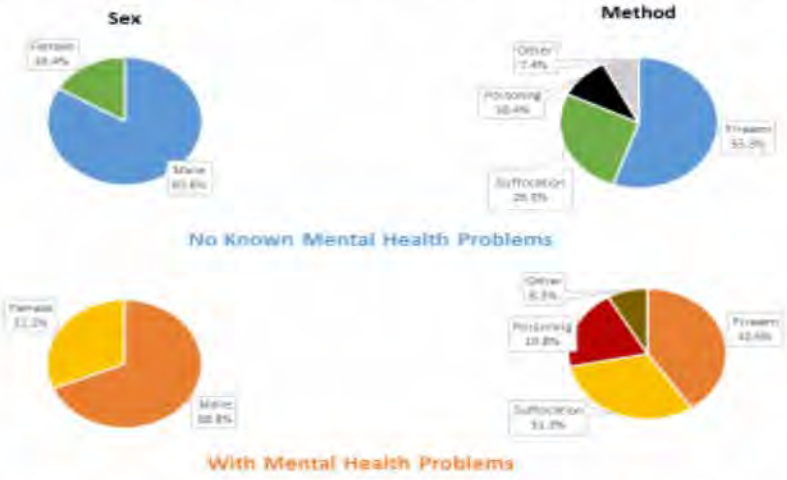
Problem: State suicide rates are increasing

Suicide rate increases ranged from 6% to 58% from 1999 through 2016

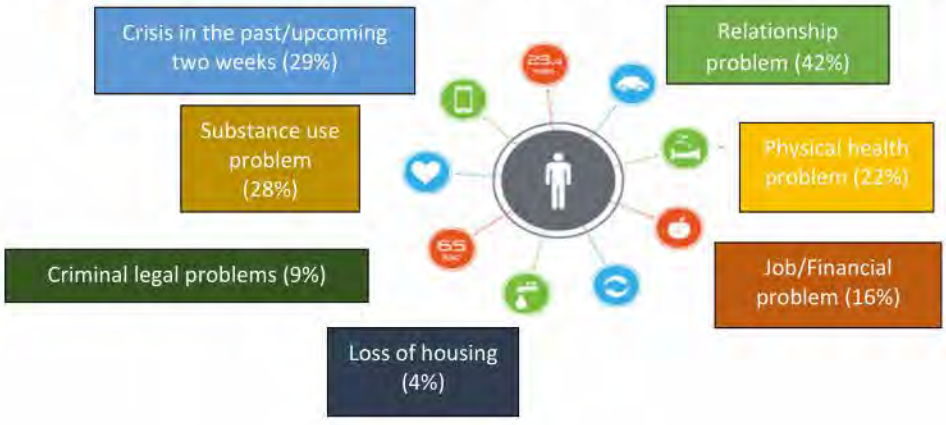


Many people who die by suicide are not known to have a mental health problem.

- People without known mental health problems are more likely to be male and to die by firearm.
- Regardless of mental health problems, 70% of suicides are among adults 25-64 years old.



Many factors contribute to suicide among those with or without mental health problems



Note: Icons below will be changed to reflect the problem listed. This is just to convey the idea]

What can states do to prevent suicides?

Use *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* to guide actions based on what is known about keeping people safe **[This could be in a banner going across the page with the link to the technical package www.cdc.gov/violenceprevention/pub/technical-packages.html]**



Share the suicide warning signs and the steps to help others [We like the new infographic you created already like the one to the left. We used to have the image on the right on the last page but it seems to fit better here so that the reader sees the warning signs and the steps together.





WHAT CAN BE DONE

The Federal government is:

- Tracking the problem to describe trends, circumstances, and populations at greatest risk (for example, see https://www.cdc.gov/violenceprevention/nvdrs/).
- Developing and evaluating suicide prevention strategies.
- Working with local, state, tribal, national, and other partners to provide guidance and distribute suicide prevention tools, (for example see www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf).

States and communities can:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Create safe and supportive environments, including securely storing medications and firearms to reduce access among people at risk.
- Connect people to others in their community so they don't feel alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

Healthcare systems can:

- Provide high quality, patient-centered, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in proven treatment options for patients who are at risk of suicide.

Employers can:

- Promote employee health and well-being, support employees at risk, and have plans in place to respond effectively.
- Encourage employees to seek help. Provide referrals to mental health, substance abuse, legal, or financial counseling services as needed.

Everyone can:

- Reduce access to lethal means, such as medications and firearms, among people at risk.
- Learn the warning signs of suicide and the steps to help identify and connect people at risk to appropriate services.
- Contact the National Suicide Prevention Lifeline for help for themselves or others: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org/



[Call out box: The media can follow existing recommendations at www.ReportingOnSuicide.org to help reduce risk (e.g., avoid dramatic headlines) and encourage people to seek help]

Preventing suicide involves everyone in the community

States can help ease unemployment and housing stress through temporary financial and housing assistance.



Provide financial support to individuals in need

Healthcare providers can make treatment available by phone or online where services are not widely available.

Strengthen access to and delivery of suicide care



Employers can put in place policies that create a healthy environment and reduce stigma about seeking help.

Create protective environments where people live, work, learn, and play



Media can describe helping resources and avoid headlines or details that increase risk.

Lessen harms and prevent future risk





Ensure people are connected to others in their community

Communities can offer activities that bring people together and reduce isolation.

Everyone can learn the signs of suicide, how best to respond, and where to get help.

Identify and support people at risk

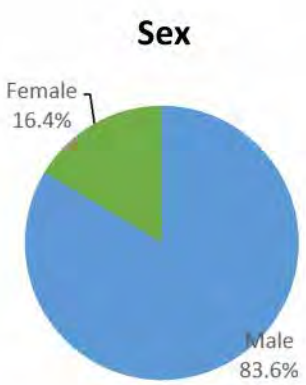
Clinicians can provide effective treatment options.

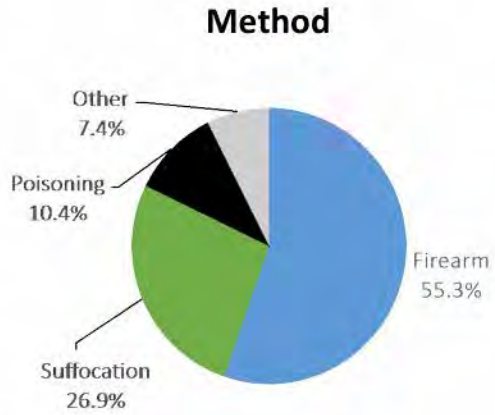


Teach coping and problem-solving skills

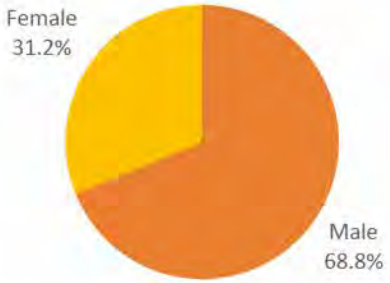
Schools can teach skills that help young people manage challenges such as relationship and school problems.

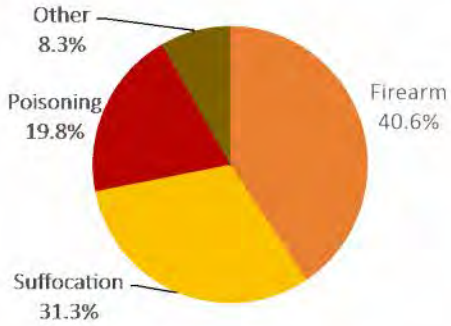






No Known Mental Health Problems





With Mental Health Problems

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 11 May 2018 17:41:43 +0000
To: Ferdon, Corinne (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC)
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Dahlberg, Linda L. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: Suicide Vital Signs brief update and fact sheet
Attachments: edits to VS FS page 3 ds.docx, 18_292322-Simon_June_2018_Suicide_v6_05.10.18_ 5.00pm ds.pdf

Offering my edits here for page 3 and for fact sheet (Tom, this is the same pdf I just sent you).
I'm really excited about the fact sheet! It looks great!
Deb

From: Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 1:08 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: Suicide Vital Signs brief update and fact sheet

Hi everyone working on this great set of products,
I think this looks great! A couple of small style things to maybe look at are below.
Cory
Page 2 of PDF, I found the following wording a bit hard to follow "Crisis in the past upcoming two weeks". Is there a slash mark or some words needed between "past" and "upcoming"?
Page 4 of PDF, sticky note of edit under "everyone can". If going to include the Lifeline number here too, may want to include a "1" to read "1-800-....)
Word document with replacement graphic. The boxes that summarize the TP strategies use a variable format. Some capitalize all words, some capitalize only first word, and others have some sort of other mix.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 10:07 AM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Greenspan, Arlene (CDC/ONDIEH/NCIPC) <aig0@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: Suicide Vital Signs brief update and fact sheet

Hi everyone,
The pre-brief with Dr. Schuchat went very well. She is highly supportive and interested in the topic of suicide prevention. She and others in the room had helpful comments and suggestions related to the range of VS materials but their comments were fairly specific and will not result in substantive changes to our approach.

We are continuing to refine the fact sheet. I have attached a copy of the fact sheet pdf with embedded stickies to describe specific edits we are making. These reflect the changes we discussed with Dr. Schuchat and the VS office during and after the pre-brief. I'm also attaching a Word document that describes the changes that we are making to page 3. We are providing shortened text for the figure that was at the top of page 3. The VS graphics artists are going to modify the layout on this page but will use the text we provided. We are also adding the 5 steps to take when you are concerned about someone who may be suicidal. This was a good outcome from the discussion at the pre-brief.
The MMWR has completed review by OADS and their comments were quite minor. We addressed them this morning and Deb will be working closely with the MMWR editors early next week to finalize the MMWR.
Please let us know if you have any questions or suggestions.
-Tom

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 2, 2018 12:59 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Greenspan, Arlene (CDC/ONDIEH/NCIPC) <aig0@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: RE: Suicide Vital Signs Fact Sheet head's up

Hi everyone,
I just received the integrated version of the fact sheet with the new graphics and latest text. As I described below, I need to get changes back to the VS office tomorrow so that they can be integrated in the version that will go to Dr. Schuchat. If you have time to review it please send me changes by cob today and I'll integrate them. If not, there will still be time next week to make changes – so this is not your last chance. I just wanted to give you an opportunity to weigh in on anything problematic before it goes to Dr. Schuchat. Our team is reviewing it at the same time.
Thank you!
-Tom

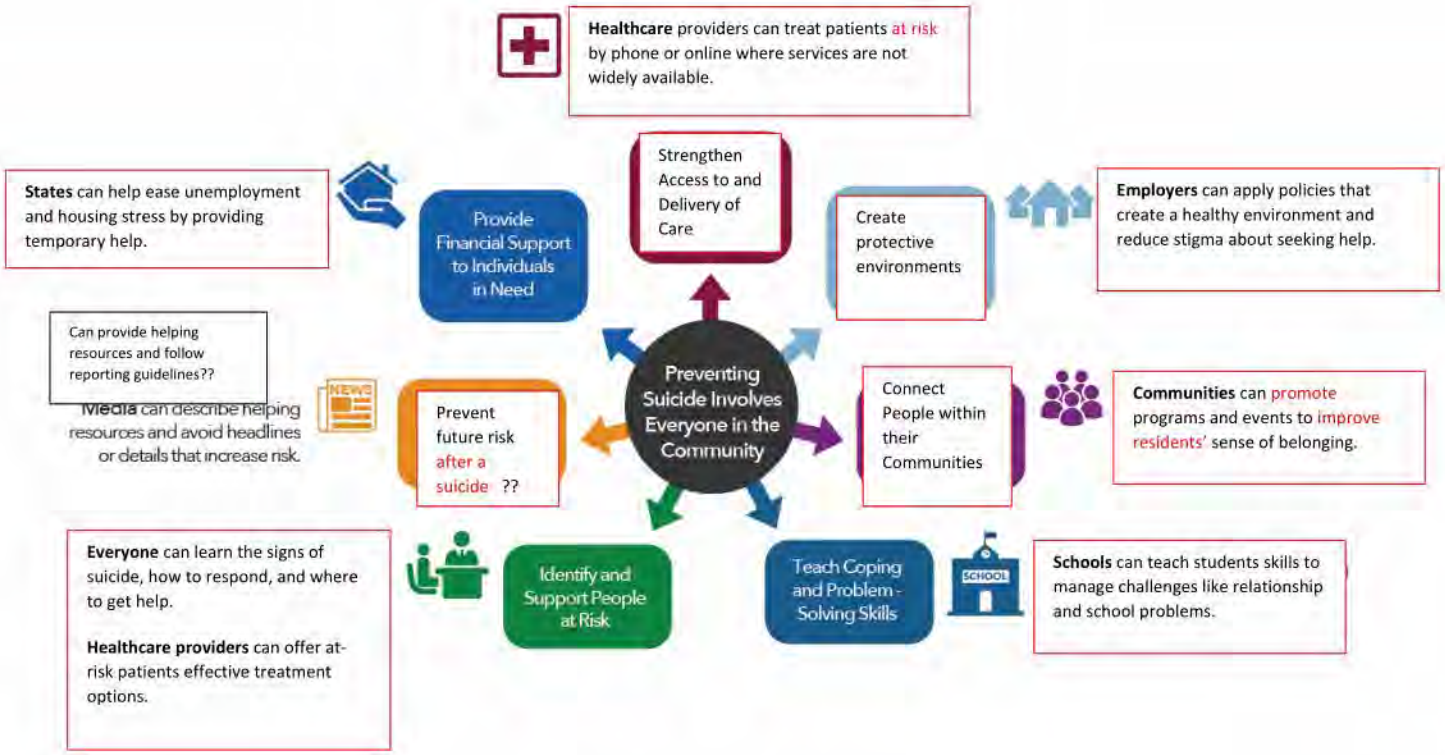
From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 1, 2018 6:04 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Greenspan, Arlene (CDC/ONDIEH/NCIPC) <aig0@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: Suicide Vital Signs Fact Sheet head's up

Hi everyone,
The fact sheet process has continued, including lots of wordsmithing types of editing but nothing too substantive. I'll share that Dr. Schuchat only had one change so far.

The VS graphic artist has been working on images separately from the wordsmithing and we have been reviewing drafts of the images.
We heard today that we should be receiving an integrated version with the text and graphics tomorrow and will need to turn it around by 10:00 a.m. on Thursday.
I wanted to give you a head's up in case you want to review it. I'll share it when it comes in tomorrow, but I won't have reviewed it yet and I know that they made changes since we last reviewed it so we'll probably have corrections/edits.
We have the pre-brief with Dr. Schuchat on Tuesday so the VS team wants to make our changes to the FS and provide it to her in advance of that meeting.
If you send changes by COB tomorrow we can make them in the version that will go to Dr. Schuchat. If you don't have time to review it tomorrow we should still be able to address your concerns next week so please still send them by Monday.
Thank you!
- Tom

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 4, 2018 4:38 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Greenspan, Arlene (CDC/ONDIEH/NCIPC) <aig0@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>
Subject: Suicide Vital Signs Fact Sheet

Hi everyone,
We had the roundtable with the VS office yesterday and it went well. We negotiated back and forth and spent a lot of time wordsmithing. For those who don't know, the round table lasts 3 hours and the focus is on getting the key messages into the VS fact sheet template. The fact sheet is 4 pages long but there are 14 pages of fact sheet rules and guidance (yes literally). Some things that might seem odd about the word choices, brevity, and headings in the draft attached are the result of this style guidance.
We and the VS team are feeling very good about where we are with this version. We think it really helps the reader to walk away knowing that suicide rates are increasing across states, that suicide is not only a mental health problem, and that there are a range of effective actions that can be taken to prevent suicide.
The team worked quickly to revise the fact sheet last night and today to incorporate the changes from the round table. We are going to continue to tweak this but we would like for you to review and please send us any requests for changes **by cob Friday**, if possible. We know that some people are on leave and won't be able to review this until Monday. We need to submit a revised version to the VS office on Tuesday. That version will be further edited by them, shared up the chain, and used to create better graphics. The graphics included now are placeholders. They have artists who will improve on these. We anticipate sharing the fact sheet with you again as it progresses but now is the time to let us know if there is anything substantial that you would like changed.
Thank you for your support on this Vital Signs!
-Tom and Deb



Note 1. Title shortened to 'WHAT CAN WE DO TO PREVENT SUICIDE?'

Note 2. We agreed to change the layout for the figures on page 3. Please use the text above to replace the original text. We are cutting about 25 words with these changes.

Note 3. There are two changes to the text of the warnings signs. Please use "Looking for a Way to Access Lethal Means" and "Talking or Posting About Wanting to Die" instead of what is there now. These changes are indicated in the pdf file too.

Note 4. The text for the steps to be listed on the right side under the warning signs should be:

5 Steps to help

- **Ask**
- **Keep them safe**
- **Be there**
- **Help them connect**
- **Follow up**

Find out why this can save a life by visiting: http://www.bethe1to.com/

Note 5. The source listed on the bottom right could be "Source: bethe1to.com" since they provide the warning signs and steps.

VS_v5_05/07/18_12:30 P.M.

#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 suicides in 2016.

↑30% Suicide rates increased more than 30% in half of US states since 1999.

50% More than half of people who died by suicide did not have a known mental health problem.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than just a mental health problem

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health problems are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health problem at the time of death. Other problems often contribute to suicide, such as relationship problems or loss, substance use disorders, physical health problems, and job, money, legal, or housing stress. Government, public health, healthcare, business, education, media and community organizations working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Connect people to others in their community so they don't feel alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



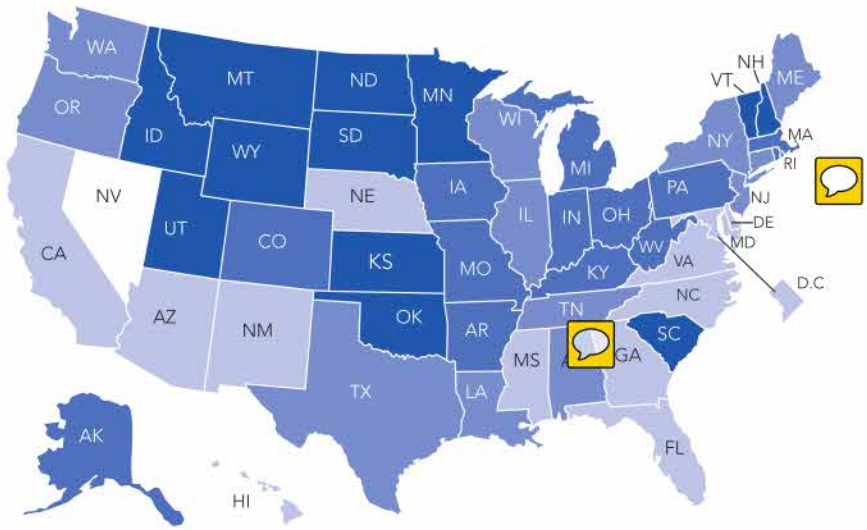
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.

Increase	38 - 58%
Increase	32 - 37%
Increase	19 - 29%
Increase	6 - 18%
Decrease	1%

SOURCE: *CDC's National Vital Statistics System.*

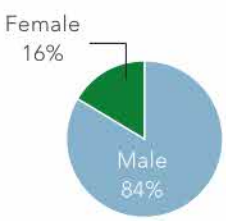


Differences exist among those with and without mental health problems.

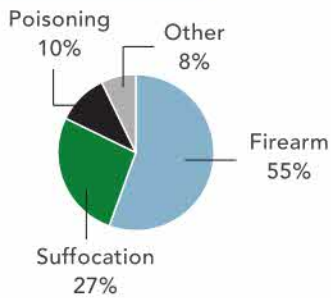
People without known mental health problems were more likely to be male and to die by firearm.

No known mental health problems

Sex

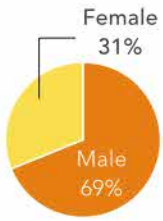


Method

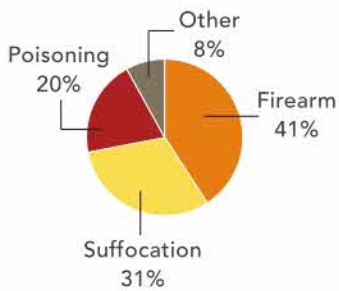


Known mental health problems

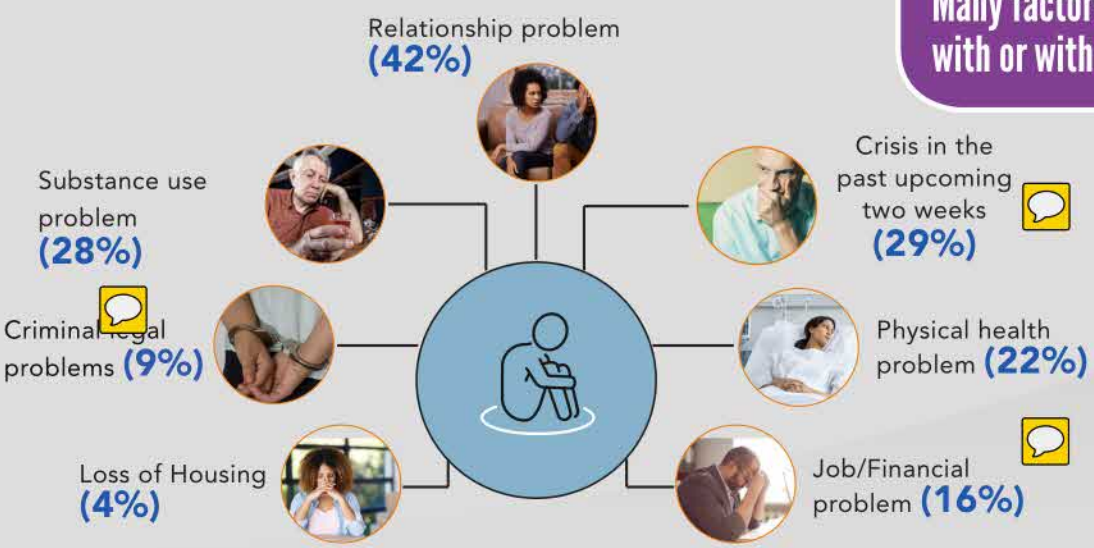
Sex



Method



Many factors contribute to suicide among those with or without mental health problems.



SOURCE: *CDC's National Violent Death Reporting System*

WHAT CAN STATES, COMMUNITIES, AND INDIVIDUALS DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc.

Healthcare providers can make services available by phone or online where treatments are not widely available.

States can help ease job loss and housing stress by providing temporary support.

Employers can put in place policies that create a healthy environment and reduce stigma about seeking help.

Media can describe helping resources and avoid headlines or details that increase risk.

Communities can offer activities that bring people together so people don't feel alone.

Everyone can learn the signs of suicide, how best to respond, and where to access help.

Healthcare providers can offer effective prevention services to those at risk.

Schools can teach skills that help young people manage challenges such as relationship and school problems.



SOURCE: CDC Vital Signs, June, 2018

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example see https://www.cdc.gov/violenceprevention/nvdrs/).
- Developing and evaluating suicide prevention strategies.
- Working with local, state, tribal, national, and other partners to provide guidance and distribute suicide prevention tools, (for example, see www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Connect people to others in their community so they don't feel alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

HEALTHCARE SYSTEMS CAN

- Provide high quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond effectively.
- Encourage employees to seek help when they need it. Provide referrals to mental health, substance use disorder, legal, or financial counseling services as needed.

EVERYONE CAN

- Reduce access to lethal means, such as medications and firearms, among people at risk.
- Learn the warning signs of suicide and the steps to help identify and connect people at risk to appropriate services. www.BeThe1To.com
- Contact the National Suicide Prevention Lifeline for help for themselves or others: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org/

The media can avoid increasing risk (e.g., with dramatic headlines, and explicit details) and encourage people to seek help using recommendations available at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018
CS292322-A

Rising suicide rates across states

More than just a mental health problem

45,000

Nearly 45,000 suicides in 2016

30%

Suicide rates increased more than 30% in half of US states ~~in the US~~

50%

More than half of people who died by suicide did not have a known mental health problem

Suicide is a leading cause of death in the US and has greatly increased in 44 states (1999-2016). Mental health problems are often seen as the sole cause, but suicide is rarely caused by a single factor. Many people who die by suicide are not known to have mental health problems at the time of death. Other issues also contribute to suicide, including failing relationships, poor health, job stress or unemployment, money, housing, and legal problems. Close coordination of civic, law enforcement, business, education, social services, faith, media, and health sectors is important for preventing suicide. States and communities can take actions now based on the best available evidence. State public health departments can be ~~the~~ leaders in bringing together the necessary community partners for action.

States and communities can:

- Identify and support people at risk of suicide.
- Lessen harms and prevent future risk of suicide.
- Teach coping and problem-solving skills to help youth and adults manage everyday challenges.
- Create safe and supportive environments where people live, work, learn, and play.
- Make sure people are connected to others in their community and don't feel alone.
- Make sure those at risk are connected to healthcare systems that include mental and physical health.
- Strengthen temporary financial and housing assistance for those struggling to make ends meet.

[INCLUDE LINK TO TECHNICAL PACKAGE: www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf]

Comment [DL(]: Seems to minimize mental health problems. "More than a mental health problem"

Comment [DL(]: I would signify this with a 'plus' or something, not an arrow (would leave the arrow to correspond to the 30% increase). Makes it seem like this is on the rise.

Comment [DL(]: Maybe note here that even with mental health problems, there are other contributing issues. (I know you're likely short on room though.) ☺

Comment [SE(]: Can contribute?

Comment [vjz7]: Haven't heard it described as failing relationships before- not sure this will make sense to layperson

Comment [DL(]: Agree. I much prefer "relationship problems"—'failing' seems like someone is to blame or there is fault.

Comment [DL(]: Other issues also contribute to suicide, including relationship problems, poor health, unemployment, legal problems, or stress

Comment [vjz7]: What about substance abuse

Comment [DL(]: Not sure this is needed (or clear)

Comment [DL(]: Maybe put health at the front of the list?

Comment [vjz7]: Can SHDs also be leaders in implementing prevention efforts (ie Colorado model). I see it as

Comment [vjz7]: This is all on the back page too so would cut here for space and add in something else

Comment [DL(]: This is VS formatting. It's duplicated on front/back.

Comment [vjz7]: I think you need to put in parentheses here who might be at risk

Comment [DL(]: Likely not room here given the FS format

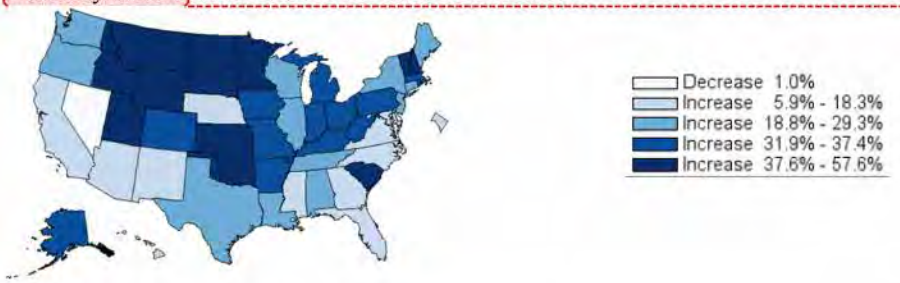
Comment [DL(]: Not sure this is clear in this context.

Comment [SE(]: This is a policy recommendation. I don't think VS does that typically, and it is a big jump from the

Comment [FC(]: All the lists of strategies in this document align with the 7 strategies in the TP. "Strengthening

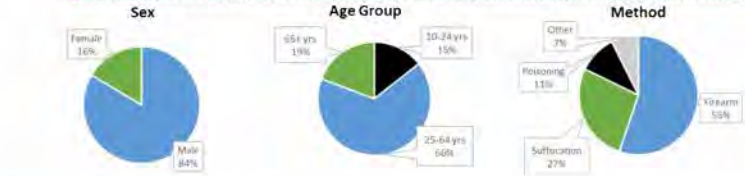
Problem: State suicide rate increases ranged from 6% to 58%

Deaths by suicide rose across the US from 1999 to 2016

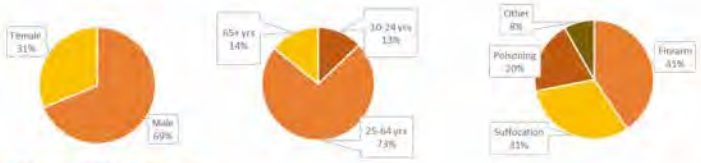


Many factors contribute to suicide

- 54% of people who died by suicide did not have a known mental health problem.



No Known Mental Health Problems



With Mental Health Problems

- Many factors contribute to suicide among those with and without mental health problems.

[Note: Icons below will be changed to reflect the problem listed. This is just to convey the idea]



Comment [FC(]: Suggest simpflying to "suicides". For accuracy, may need it to be "suicide rates"

Comment [FC(]: Check % with 10-24 non-MH group. MMWR reflects 14.4%

Check % of poisoning non-MH group. MMWR reflects 10.4

Comment [FC(]: Seems to be a repeat of the header (Many factors contribute to suicide) so maybe alter wording in one of the two places.

I like the graphic approach below. May want to add a specifying descriptor to "housing" in the graphic. Maybe unstable housing or loss of housing.

Comment [vjz7]: I like this concept below

States are seeing increases. What can they do prevent suicides?

Use *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* to make decisions based on the best evidence ~~for suicide prevention~~ **[This could be in a banner going across the page with the link to the technical package** www.cdc.gov/violenceprevention/pub/technical-packages.html**]**



[Create an infographic like the one below that lists warning signs. It will be updated to reflect the latest guidance on warning signs]



Comment [FC(]: To save words, this phrasing could come out since the point is clear from the title fo the TP

Comment [vjz7]: In graphic below or somewhere in this document need to address stigma

mment [FC(]: I understand why these ategy descriptions here are slightly ferent than how worded in TP. Linda is rking with a few folks (maybe PPTB d communication) to come up with ne plainer language descriptions. ght want to make sure modifications e are consistent with what is being ne elsewhere or vice versa. Also, tner input informed the wording in the so it might be good to have Linda look s over (and as this evolves) so we keep tner perspectives in mind.

Deb's point above, reducing stigma is a t of the create protective vironments strategy in the TP, so nsider weaving in there.

WHAT CAN BE DONE



The Federal government is:

- Tracking and monitoring the problem.
- Sharing information on actions proven to prevent suicide.
- Working with ~~other~~ local, state, and ~~federal governmental agencies~~tribal partners to prevent suicide.

States and communities can:

- Identify and support people at risk of suicide.
- Lessen harms and prevent future risk of suicide.
- Teach coping and problem-solving skills to help youth and adults manage ~~everyday~~ challenges.
- Create safe and supportive environments where people live, work, learn, and play.
- Make sure people are connected to others in their community and don't feel alone.
- Make sure those at risk are connected to healthcare systems that include mental and physical health.
- Strengthen temporary financial and housing assistance for those struggling to make ends meet.

Healthcare systems can

- Make sure entire healthcare systems provide high quality, ongoing care, focusing on suicide prevention.
- Make sure healthcare is easily accessible and provide options such as telecommunications in areas where services aren't available.
- Provide personalized, proven treatment plans for patients at risk of suicide.

Employers can:

- Promote employee health and well-being, support people at risk, and have plans in place to respond to risk effectively.
- Train all employees about suicide risk and prevention.
- Encourage employees to seek help and provide referrals to mental health, substance abuse, or financial counseling services as needed.

Everyone can:

- Reduce access to lethal means, such as medications and firerams, among people at risk.
- Learn the warning signs of suicide to help identify and refer people at risk.
- Contact the National Suicide Prevention Lifeline for help for themselves or others: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org/

[Call out box: The media can encourage help-seeking and avoid dramatic headlines using guidelines at www.ReportingOnSuicide.org]

Comment [vjz7]: Should NVDRS be highlighted somewhere that states can use their data to tailor prevention efforts

Comment [FC(]: Based on the lead in, seems like the wording in this one needs to be different. Seems like it may have originally been worded what is CDC doing. Also, can we add tribes? Tracked idea.

Comment [SE(]: Same comment as above

Comment [FC(]: Not sure this is the right word. Maybe it should be something like "....and use strategies such as telephone and web-based technology to reach areas with limited servies."

Comment [vjz7]: Such as?

Comment [DL(]: Since this is mentioned here, would def see about including up in the front of the fact sheet as Deb suggested

Comment [FC(]: I know from conversations with Tom it was hard to get this in. Based in part of our Epi-Aids and research, I think it is really important to keep in and perhaps expand slightly as space permits. Idea:
Medica can reduce risk by:
Avoiding dramatic headlines or sensationalizing with photos
Encouraging help seeking and providing crisis phone numbers
Reporting without including details of methods

Comment [vjz7]: This is important

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 6 Jun 2018 16:49:09 -0400
To: Sokler, Lynn (CDC/OD/OADC)
Cc: Black, Erin (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: Supplemental Table- FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention

Thanks Lynn!

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Wednesday, June 6, 2018 4:44 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Cc: Black, Erin (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: Supplemental Table- FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention

Thanks, updated and have recent it out.

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 4:23 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: RE: Supplemental Table- FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention
Importance: High

Hi Lynn – I wanted to let you know that the Dear Colleague letter says the materials will be release on Tuesday June 7 not Thursday June 7.
Malia

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Wednesday, June 6, 2018 4:20 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Gaines-McCollom, Molly (CDC/OPHPR/DEO) <iwg9@cdc.gov>; DeNoon, Daniel (CDC/OD/OADC) (CTR) <xlz4@cdc.gov>; Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>; Hoskins, Sharon (K.D.) (CDC/OD/OADC) <sdh4@cdc.gov>; Iverson, Dontae (CDC/OD/OADC) <liz8@cdc.gov>; Balluz, Lina (ATSDR/DTHHS/OD) <lib7@cdc.gov>; Bonds, Michelle E. (CDC/OD/OADC) <meb0@cdc.gov>; Brand, Anstice M. (CDC/OD/CDCWO) <atb6@cdc.gov>; Brown, Renee (CDC/ONDIEH/NCCDPHP) <ryb8@cdc.gov>; Bumpus, Stefanie (CDC/OID/NCEZID) <wve1@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Burns, Annina (CDC/OD/CDCWO) <vjg7@cdc.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; Clark, Cynthia K. (CDC/OD/OCS) <cfc8@cdc.gov>; Crawford, Carol Y. (CDC/OD/OADC) <cjy1@cdc.gov>; Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>; Das, Mansi S. (CDC/OD/OADC) <hrg7@cdc.gov>; Dempsey, Jay H. (CDC/OD/OADC) <ifb5@cdc.gov>; Diaz, Shelly S. (CDC/OID/NCHHSTP) <erh8@cdc.gov>; Dills,

Kimberly C. (ATSDR/OPPE) <kid4@cdc.gov>; DPAID (CDC) <dpaid@cdc.gov>; Dunn, Evelyn (CDC/OCOO/OFR/OA) <edm2@cdc.gov>; Galatas, Kate (CDC/OD/OADC) <kkg2@cdc.gov>; Gonzalez, Belsie (CDC/OD/OADC) <fqi1@cdc.gov>; Grant, Llelwyn (CDC/OD/OADC) <lcg7@cdc.gov>; Green, Hugh (CDC/OD/OCS) <yke8@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>; Heldman, Amy B. (CDC/OD/OADC) <evd4@cdc.gov>; Hogg, Jarrad (CDC/OD/OADC) <isr5@cdc.gov>; Hoo, Elizabeth (CDC/OD/PPEO) <irp5@cdc.gov>; Iademarco, Michael (CDC/OPHSS/CSELS/OD) <mai9@cdc.gov>; Joyner, Tonya (CDC/OSTLTS/OD) (CTR) <wyl6@cdc.gov>; Kelly, Alison (CDC/OCOO/OFR/OA) <ayk7@cdc.gov>; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>; Knight, Dianna (CDC/OD/OADC) <fpz0@cdc.gov>; Knotts, Ashley (CDC/OD/OCS) <vqf0@cdc.gov>; Kroop, Seth (CDC/OD/OCS) <wpw7@cdc.gov>; Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD) <wrm0@cdc.gov>; Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD) <lym1@cdc.gov>; McGowan, Robert (Kyle) (CDC/OD/OCS) <omc2@cdc.gov>; Olivares, Dagny (CDC/OSTLTS/OD) <dvp2@cdc.gov>; Parikh, Sapana (CDC/OCOO/OFR/OA) <euh8@cdc.gov>; Parker, Stacey M. (CDC/OSTLTS/OD) (CTR) <vgw3@cdc.gov>; Payne, Chelsea C. (CDC/OSTLTS/OD) <cec4@cdc.gov>; Putman, Ami D. (CDC/OPHSS/CSELS/DLS) <ibv5@cdc.gov>; Rasmussen, Sonja (CDC/OID/OD) <skr9@cdc.gov>; Redd, Stephen (CDC/OPHPR/OD) <scr1@cdc.gov>; Redfield, Robert R. (CDC/OD) <olx1@cdc.gov>; Schattner, Aimee (CDC/OD/CDCWO) <xjj4@cdc.gov>; Schindelar, Jessica (CDC/OD/OADC) <ghq1@cdc.gov>; Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; Simon, Gia M. (CDC/OSTLTS/OD) <wpc8@cdc.gov>; Smith, Patti (CDC/OD/OADC) <pab0@cdc.gov>; Sorrells, Marjorie J. (CDC/OD/OCS) <isg8@cdc.gov>; Stanojevich, Joel G. (CDC/CGH/OD) <vhi9@cdc.gov>; Ware, Nina (CDC/OD/OADS) <evy5@cdc.gov>; Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID) <aoe8@cdc.gov>; Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR) <kcv7@cdc.gov>; Wilson, Michelle (CDC/OCOO/OFR/OA) <zwv2@cdc.gov>

Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Turner, Cheryl L. (CDC/OD/OADC) (CTR) <ffd0@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>; McGuire, Delaney (CDC/OD/OADC) <mze7@cdc.gov>; Roberts, Ursula (CDC/OD/OCS) (CTR) <nka7@cdc.gov>

Subject: Supplemental Table- FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention

Hi Folks,

Sending a table that will appear in the MMWR. For those of you distributing to others tomorrow morning, please include the table with the other materials.

Thanks, Lynn

From: Sokler, Lynn (CDC/OD/OADC)

Sent: Wednesday, June 6, 2018 2:33 PM

To: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Gaines-McCollom, Molly (CDC/OPHPR/DEO) <iwg9@cdc.gov>; DeNoon, Daniel (CDC/OD/OADC) (CTR) <xlz4@cdc.gov>; Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>; Hoskins, Sharon (K.D.) (CDC/OD/OADC) <sdh4@cdc.gov>; Iverson, Dontae (CDC/OD/OADC) <liz8@cdc.gov>; Balluz, Lina (ATSDR/DTHHS/OD) <lib7@cdc.gov>; Bonds, Michelle E. (CDC/OD/OADC) <meb0@cdc.gov>; Brand, Anstice M. (CDC/OD/CDCWO) <atb6@cdc.gov>; Brown, Renee (CDC/ONDIEH/NCCDPHP) <ryb8@cdc.gov>; Bumpus, Stefanie (CDC/OID/NCEZID) <wve1@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Burns, Annina

(CDC/OD/CDCWO) <vjg7@cdc.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; Clark, Cynthia K. (CDC/OD/OCS) <cfc8@cdc.gov>; Crawford, Carol Y. (CDC/OD/OADC) <cjy1@cdc.gov>; Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>; Das, Mansi S. (CDC/OD/OADC) <hrg7@cdc.gov>; Dempsey, Jay H. (CDC/OD/OADC) <ifb5@cdc.gov>; Diaz, Shelly S. (CDC/OID/NCHHSTP) <erh8@cdc.gov>; Dills, Kimberly C. (ATSDR/OPPE) <kid4@cdc.gov>; DPAID (CDC) <dpaid@cdc.gov>; Dunn, Evelyn (CDC/OCOO/OFR/OA) <edm2@cdc.gov>; Galatas, Kate (CDC/OD/OADC) <kkg2@cdc.gov>; Gonzalez, Belsie (CDC/OD/OADC) <fqi1@cdc.gov>; Grant, Llelwyn (CDC/OD/OADC) <lcg7@cdc.gov>; Green, Hugh (CDC/OD/OCS) <yke8@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>; Heldman, Amy B. (CDC/OD/OADC) <evd4@cdc.gov>; Hogg, Jarrad (CDC/OD/OADC) <isr5@cdc.gov>; Hoo, Elizabeth (CDC/OD/PPEO) <irp5@cdc.gov>; Iademarco, Michael (CDC/OPHSS/CSELS/OD) <mai9@cdc.gov>; Joyner, Tonya (CDC/OSTLTS/OD) (CTR) <wyl6@cdc.gov>; Kelly, Alison (CDC/OCOO/OFR/OA) <ayk7@cdc.gov>; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>; Knight, Dianna (CDC/OD/OADC) <fpz0@cdc.gov>; Knotts, Ashley (CDC/OD/OCS) <vqf0@cdc.gov>; Kroop, Seth (CDC/OD/OCS) <wpw7@cdc.gov>; Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD) <wrm0@cdc.gov>; Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD) <lym1@cdc.gov>; McGowan, Robert (Kyle) (CDC/OD/OCS) <omc2@cdc.gov>; Olivares, Dagny (CDC/OSTLTS/OD) <dvp2@cdc.gov>; Parikh, Sapana (CDC/OCOO/OFR/OA) <euh8@cdc.gov>; Parker, Stacey M. (CDC/OSTLTS/OD) (CTR) <vgw3@cdc.gov>; Payne, Chelsea C. (CDC/OSTLTS/OD) <cec4@cdc.gov>; Putman, Ami D. (CDC/OPHSS/CSELS/DLS) <ibv5@cdc.gov>; Rasmussen, Sonja (CDC/OID/OD) <skr9@cdc.gov>; Redd, Stephen (CDC/OPHPR/OD) <scr1@cdc.gov>; Redfield, Robert R. (CDC/OD) <olx1@cdc.gov>; Schattner, Aimee (CDC/OD/CDCWO) <xjj4@cdc.gov>; Schindelar, Jessica (CDC/OD/OADC) <ghq1@cdc.gov>; Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; Simon, Gia M. (CDC/OSTLTS/OD) <wpc8@cdc.gov>; Smith, Patti (CDC/OD/OADC) <pab0@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Sorrells, Marjorie J. (CDC/OD/OCS) <isg8@cdc.gov>; Stanojevich, Joel G. (CDC/CGH/OD) <vhi9@cdc.gov>; Ware, Nina (CDC/OD/OADS) <evy5@cdc.gov>; Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID) <aoe8@cdc.gov>; Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR) <kcv7@cdc.gov>; Wilson, Michelle (CDC/OCOO/OFR/OA) <zwv2@cdc.gov>

Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Turner, Cheryl L. (CDC/OD/OADC) (CTR) <ffd0@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>; McGuire, Delaney (CDC/OD/OADC) <mze7@cdc.gov>; Roberts, Ursula (CDC/OD/OCS) (CTR) <nka7@cdc.gov>

Subject: FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention

Hi Folks,

This month's issue of Vital Signs is on **Suicide Rates Rising across the U.S.** and releases **Thursday, June 7** with a Media Telebriefing at noon. **All materials go live on the CDC website at 1 pm**. Here are the key materials to use to distribute to stakeholders and partners: The Dear Colleague letter, MMWR, Fact Sheet, Press Release and Graphic.

For those distributing to media, please send the MMWR, Fact Sheet, Press Release and Graphic. Dr. Schuchat will be the primary spokesperson for this Vital Signs.

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For each Vital Signs issue, we track and report on results **two times** – after 24 hours and after 30 days. We track the number of audiences reached (from all media and web sources), # of stories and type of media, the dollar value of the media coverage if CDC had to purchase it as advertising, social media use and reuse, and # of people looking at Vital Signs on our web pages.

Vital Signs reaches out to a lot of different people with our topics and, from our evaluation surveys, the uptake out in the field is impressive. In a survey, an astounding **95%** of state health officers and state epidemiologists were aware of and used VS issues, with about 3 in 4 using VS in the past year. All shared the material with their constituents via conference call, e-mail, newsletter, or mailing for topics appropriate to their members. A stratified random sample survey, used with NACCHO member organizations, reported that **74%** of all county or local health departments had heard of or used VS in the past year to educate staff, improve programs, and guide policy formation. As well, a 2017 internal evaluation showed that most program staff involved believe the value derived from it is worth the work, although producing Vital Signs takes a lot of effort.

I want to thank everyone who has worked on this issue for all their extra efforts. It's a very important topic and will be valuable information for many people. We hope that program continues to use this Vital Signs to promote its messages and the recommended actions in it to achieve new results.

Cheers,

Lynn

Lynn A. Sokler|Senior Communication Advisor|Office of the Director|Office of the Associate Director for Communication| Centers for Disease Control and Prevention|Mailing: 1600 Clifton Road MS-E-69| Atlanta, GA 30329| zsz0@cdc.gov| office 404-498-6617 |bus. cell 404-409-5556|fx 404-498-0945



From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 6 Jun 2018 16:23:28 -0400
To: Sokler, Lynn (CDC/OD/OADC)
Cc: Black, Erin (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: Supplemental Table- FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention
Attachments: DEAR COLLEAGUE_V2_5.15.18.13.02pm_rev_Final.DOCX
Importance: High

Hi Lynn – I wanted to let you know that the Dear Colleague letter says the materials will be release on Tuesday June 7 not Thursday June 7.
Malia

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Wednesday, June 6, 2018 4:20 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) ; Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Dorigo, Leslie (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Gaines-McCollom, Molly (CDC/OPHPR/DEO) ; DeNoon, Daniel (CDC/OD/OADC) (CTR) ; Grusich, Katherina (Kate) (CDC/OD/OADC) ; Hoskins, Sharon (K.D.) (CDC/OD/OADC) ; Iverson, Dontae (CDC/OD/OADC) ; Balluz, Lina (ATSDR/DTHHS/OD) ; Bonds, Michelle E. (CDC/OD/OADC) ; Brand, Anstice M. (CDC/OD/CDCWO) ; Brown, Renee (CDC/ONDIEH/NCCDPHP) ; Bumpus, Stefanie (CDC/OID/NCEZID) ; Burden, Bernadette (CDC/OD/OADC) ; Burns, Annina (CDC/OD/CDCWO) ; Charles, Julia (CDC/OD/OCS) ; Clark, Cynthia K. (CDC/OD/OCS) ; Crawford, Carol Y. (CDC/OD/OADC) ; Daniel, Katherine Lyon (CDC/OD/OADC) ; Das, Mansi S. (CDC/OD/OADC) ; Dempsey, Jay H. (CDC/OD/OADC) ; Diaz, Shelly S. (CDC/OID/NCHHSTP) ; Dills, Kimberly C. (ATSDR/OPPE) ; DPAID (CDC) ; Dunn, Evelyn (CDC/OCOO/OFR/OA) ; Galatas, Kate (CDC/OD/OADC) ; Gonzalez, Belsie (CDC/OD/OADC) ; Grant, Llelwyn (CDC/OD/OADC) ; Green, Hugh (CDC/OD/OCS) ; Guest, Megan (CDC/OD/OADC) ; Heldman, Amy B. (CDC/OD/OADC) ; Hogg, Jarrad (CDC/OD/OADC) ; Hoo, Elizabeth (CDC/OD/PPEO) ; Iademarco, Michael (CDC/OPHSS/CSELS/OD) ; Joyner, Tonya (CDC/OSTLTS/OD) (CTR) ; Kelly, Alison (CDC/OCOO/OFR/OA) ; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) ; Knight, Dianna (CDC/OD/OADC) ; Knotts, Ashley (CDC/OD/OCS) ; Kroop, Seth (CDC/OD/OCS) ; Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD) ; Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD) ; McGowan, Robert (Kyle) (CDC/OD/OCS) ; Olivares, Dagny (CDC/OSTLTS/OD) ; Parikh, Sapana (CDC/OCOO/OFR/OA) ; Parker, Stacey M. (CDC/OSTLTS/OD) (CTR) ; Payne, Chelsea C. (CDC/OSTLTS/OD) ; Putman, Ami D. (CDC/OPHSS/CSELS/DLS) ; Rasmussen, Sonja (CDC/OID/OD) ; Redd, Stephen (CDC/OPHPR/OD) ; Redfield, Robert R. (CDC/OD) ; Schattner, Aimee (CDC/OD/CDCWO) ; Schindelar, Jessica (CDC/OD/OADC) ; Schuchat, Anne MD (CDC/OD) ; Simon, Gia M. (CDC/OSTLTS/OD) ; Smith, Patti (CDC/OD/OADC) ; Sorrells, Marjorie J. (CDC/OD/OCS) ; Stanojevich, Joel G. (CDC/CGH/OD) ; Ware, Nina (CDC/OD/OADS) ; Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID) ; Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR) ; Wilson, Michelle (CDC/OCOO/OFR/OA)
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) ; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) ; Omisore, Shannon L. (CDC/OD/OADC) ; Turner, Cheryl L. (CDC/OD/OADC) (CTR) ; Guest, Megan (CDC/OD/OADC) ; McGuire, Delaney (CDC/OD/OADC) ; Roberts, Ursula (CDC/OD/OCS) (CTR)
Subject: Supplemental Table- FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention
Hi Folks,

Sending a table that will appear in the MMWR. For those of you distributing to others tomorrow morning, please include the table with the other materials.
Thanks, Lynn

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Wednesday, June 6, 2018 2:33 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Gaines-McCollom, Molly (CDC/OPHPR/DEO) <iwg9@cdc.gov>; DeNoon, Daniel (CDC/OD/OADC) (CTR) <xlz4@cdc.gov>; Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>; Hoskins, Sharon (K.D.) (CDC/OD/OADC) <sdh4@cdc.gov>; Iverson, Dontae (CDC/OD/OADC) <liz8@cdc.gov>; Balluz, Lina (ATSDR/DTHHS/OD) <lib7@cdc.gov>; Bonds, Michelle E. (CDC/OD/OADC) <meb0@cdc.gov>; Brand, Anstice M. (CDC/OD/CDCWO) <atb6@cdc.gov>; Brown, Renee (CDC/ONDIEH/NCCDPHP) <ryb8@cdc.gov>; Bumpus, Stefanie (CDC/OID/NCEZID) <wve1@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Burns, Annina (CDC/OD/CDCWO) <vjg7@cdc.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; Clark, Cynthia K. (CDC/OD/OCS) <cfc8@cdc.gov>; Crawford, Carol Y. (CDC/OD/OADC) <cjy1@cdc.gov>; Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>; Das, Mansi S. (CDC/OD/OADC) <hrg7@cdc.gov>; Dempsey, Jay H. (CDC/OD/OADC) <ifb5@cdc.gov>; Diaz, Shelly S. (CDC/OID/NCHHSTP) <erh8@cdc.gov>; Dills, Kimberly C. (ATSDR/OPPE) <kid4@cdc.gov>; DPAID (CDC) <dpaid@cdc.gov>; Dunn, Evelyn (CDC/OCOO/OFR/OA) <edm2@cdc.gov>; Galatas, Kate (CDC/OD/OADC) <kkg2@cdc.gov>; Gonzalez, Belsie (CDC/OD/OADC) <fqi1@cdc.gov>; Grant, Llelwyn (CDC/OD/OADC) <lcg7@cdc.gov>; Green, Hugh (CDC/OD/OCS) <yke8@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>; Heldman, Amy B. (CDC/OD/OADC) <evd4@cdc.gov>; Hogg, Jarrad (CDC/OD/OADC) <isr5@cdc.gov>; Hoo, Elizabeth (CDC/OD/PPEO) <irp5@cdc.gov>; Iademarco, Michael (CDC/OPHSS/CSELS/OD) <mai9@cdc.gov>; Joyner, Tonya (CDC/OSTLTS/OD) (CTR) <wyl6@cdc.gov>; Kelly, Alison (CDC/OCOO/OFR/OA) <ayk7@cdc.gov>; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>; Knight, Dianna (CDC/OD/OADC) <fpz0@cdc.gov>; Knotts, Ashley (CDC/OD/OCS) <vqf0@cdc.gov>; Kroop, Seth (CDC/OD/OCS) <wpw7@cdc.gov>; Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD) <wrm0@cdc.gov>; Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD) <lym1@cdc.gov>; McGowan, Robert (Kyle) (CDC/OD/OCS) <omc2@cdc.gov>; Olivares, Dagny (CDC/OSTLTS/OD) <dvp2@cdc.gov>; Parikh, Sapana (CDC/OCOO/OFR/OA) <euh8@cdc.gov>; Parker, Stacey M. (CDC/OSTLTS/OD) (CTR) <vgw3@cdc.gov>; Payne, Chelsea C. (CDC/OSTLTS/OD) <cec4@cdc.gov>; Putman, Ami D. (CDC/OPHSS/CSELS/DLS) <ibv5@cdc.gov>; Rasmussen, Sonja (CDC/OID/OD) <skr9@cdc.gov>; Redd, Stephen (CDC/OPHPR/OD) <scr1@cdc.gov>; Redfield, Robert R. (CDC/OD) <olx1@cdc.gov>; Schattner, Aimee (CDC/OD/CDCWO) <xjj4@cdc.gov>; Schindelar, Jessica (CDC/OD/OADC) <ghq1@cdc.gov>; Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; Simon, Gia M. (CDC/OSTLTS/OD) <wpc8@cdc.gov>; Smith, Patti (CDC/OD/OADC) <pab0@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Sorrells, Marjorie J. (CDC/OD/OCS) <isg8@cdc.gov>; Stanojevich, Joel G. (CDC/CGH/OD) <vhi9@cdc.gov>; Ware, Nina (CDC/OD/OADS) <evy5@cdc.gov>; Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID) <aoe8@cdc.gov>; Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR) <kcv7@cdc.gov>; Wilson, Michelle (CDC/OCOO/OFR/OA) <zwv2@cdc.gov>
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Lynn

Lynn A. Sokler|Senior Communication Advisor|Office of the Director|Office of the Associate Director for Communication| Centers for Disease Control and Prevention|Mailing: 1600 Clifton Road MS-E-69| Atlanta, GA 30329| zszo@cdc.gov| office 404-498-6617 |bus. cell 404-409-5556|fx 404-498-0945



Dear Colleague:

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Tuesday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Web page to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Thank you for your support.

Debra Houry, MD, MPH
Director
National Center for Injury Prevention and Control

James A. Mercy, PhD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control

From: Girod, Candace (CDC/ONDIEH/NCIPC)
Sent: 4 Jan 2018 08:55:46 -0500
To: Herbst, Jeffrey (CDC/ONDIEH/NCIPC);Bartholow, Brad (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Marshall, Khiya J. (CDC/ONDIEH/NCIPC)
Subject: RE: Technical Package Citation Scan

Hey Deb,
I'm not sure how you'll be choosing key informants to interview, but there were suicide prevention coalitions in 17 states that posted about the technical package, so it may be a good idea to chat with folks from a few of them.
Best,
Candace

From: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Sent: Wednesday, January 03, 2018 3:36 PM
To: Bartholow, Brad (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Girod, Candace (CDC/ONDIEH/NCIPC)
Subject: FW: Technical Package Citation Scan
Sharing great news from Candace!!

From: Girod, Candace (CDC/ONDIEH/NCIPC)
Sent: Wednesday, January 3, 2018 3:20 PM
To: Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>
Cc: Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Subject: Technical Package Citation Scan
Hey Jeff and Linda,
I'm attaching a spreadsheet with any websites that mention the technical packages. This doesn't include any journal articles.
One interesting takeaway was that of the 208 websites I found, almost 70 cited the suicide technical package.
I will find a good way to summarize all of my findings in the next TP update.
Best,
Candace

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 13 Apr 2018 14:47:12 +0000
To: Bartholow, Brad (CDC/ONDIEH/NCIPC)
Subject: RE: Update: Suicide Prevention in PR and USVI (hurricane supplement)

I mean it just makes sense! Keep up the fight! And don't get fired. ;)

From: Bartholow, Brad (CDC/ONDIEH/NCIPC)
Sent: Friday, April 13, 2018 10:42 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Update: Suicide Prevention in PR and USVI (hurricane supplement)

I've been a thorn in their side recently re PPTB and no suicide SMEs. I'll continue to do so.
-b

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Friday, April 13, 2018 10:31 AM
To: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Subject: RE: Update: Suicide Prevention in PR and USVI (hurricane supplement)

Thanks for sharing this! You're right about PPTB! Kimberley said they still can't hire anyone on her team. SMH.
Deb

From: Bartholow, Brad (CDC/ONDIEH/NCIPC)
Sent: Friday, April 13, 2018 10:25 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: FW: Update: Suicide Prevention in PR and USVI (hurricane supplement)

FYI..

From: Bartholow, Brad (CDC/ONDIEH/NCIPC)
Sent: Friday, April 13, 2018 9:49 AM
To: Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>
Cc: Cephas Childers, Kendell (CDC/ONDIEH/NCIPC) <koc9@cdc.gov>
Subject: RE: Update: Suicide Prevention in PR and USVI (hurricane supplement)

Hi Jeff,
I have talked to Deb about this. She has been on the calls but has not been tapped to doing anything at the moment. She would be willing to support these efforts, however, given work-life balance issues would prefer to keep these demands to a minimum. It has been a few weeks since I've discussed with Melissa. Melissa would be the most appropriate person to help out with this and continues to contribute to the development of various resource materials related to post-disaster issues/needs, although these requests may be independent of the supplemental funding and more related to her prior engagement with the EOC. I tried calling Melissa this morning about this, however, she is on leave and I could not reach her. Also, while I am very interested in supporting this initiative and identifying opportunities to support the PR/USVI supplemental funding initiatives and engage staff in critical and interesting public health projects, as mentioned during our 2:1 this week, I am concerned about Melissa's work load and am looking for opportunities to off-load some work for her. It would be fabulous if PPTB could hire a suicide SME given all of the TP implementation needs, the Colorado Collaborative project, and the growing suicide-related work demands. If DVP is going to have a balanced and coordinated suicide-related workforce, then a SME in PPTB would be indicated.
If we can get the Title 42 on-boarded and if we select someone who can hit the ground running, they could also help to support this work.
Hope this helps.

Brad

From: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Sent: Friday, April 13, 2018 9:15 AM
To: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Cc: Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Cephas Childers, Kendell (CDC/ONDIEH/NCIPC) <koc9@cdc.gov>
Subject: FW: Update: Suicide Prevention in PR and USVI (hurricane supplement)

Good morning Brad –

Have you had a chance to discuss with Deb and Melissa if they have been asked to continue supporting these efforts, especially post-funding? I just spoke with Gayle Payne who recently learned that the programmatic NOFO efforts will be assigned to PPTB, but the branch currently does not employ a suicide SME project officer.

Please let me know. Thanks, Jeff

From: Young, Joni (CDC/ONDIEH/NCIPC)
Sent: Thursday, April 12, 2018 5:34 PM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Mercado-Crespo, Melissa (CDC/ONDIEH/NCIPC) <cju8@cdc.gov>; Payne, Gayle H. (CDC/ONDIEH/NCIPC) <hfn5@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>; Gervin, Derrick (CDC/ONDIEH/NCIPC) <vjk8@cdc.gov>; Barnes, Jamar (CDC/ONDIEH/NCIPC) <zee9@cdc.gov>; Arroyo-Ortiz, Ana L. (CDC/ONDIEH/NCIPC) <ala2@cdc.gov>; Roby, Sarah (CDC/ONDIEH/NCIPC) <mkq4@cdc.gov>; Cameron, Daniel N. (CDC/ONDIEH/NCIPC) <dxc1@cdc.gov>
Cc: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Blair, Janet (CDC/ONDIEH/NCIPC) <zud5@cdc.gov>; Lowe, Ericka R. (CDC/ONDIEH/NCIPC) <erl2@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>
Subject: Update: Suicide Prevention in PR and USVI (hurricane supplement)

Hi Everyone,

I wanted to share updates on status of the hurricane supplemental funding for suicide prevention in Puerto Rico and USVI. Things are moving along and our spend plan currently supports the following activities, along with their status:

- **DSLR crisis NOFO** - Projects were shared with the jurisdictions on March 30 and we are in the 45-day window to discuss with them. I have reached out to set up calls with USVI and PR.
- **Communications contract** – We added our communications activities to this as it meant to complement the DSLR crisis NOFO. They anticipate an award in mid-May; this will get health comm staff on the ground in PR and USVI in mid/late June.
- **Translation of technical package into Spanish** – The order has been placed and we anticipate it will take approximately 4 weeks.
- **NVDRS supplement to PR** – Jamar has working closely with OGS on the sole source justification and we don't anticipate any issues.
- **OSTLTS Crisis Partnership NOFO** – This is pending objective review and awards for the umbrella mechanism. They will eventually provide to us the names and capabilities of the partners; the jurisdictions or CIOs can utilize this mechanism as needed and they are aiming to get awards out about the same time (May/June). This could be a good way to help support PR or USVI if they

need additional capacity or partners to help take on the activities proposed under the DSLR crisis NOFO. At this time we have not allocated funds towards this mechanism.

- **Project officer and SME support** – This is to help support percentages of current FTE time and still TBD; we can determine how to allocate the funding once we have a better idea of the proposals from PR and USVI.
- **Contract position** – This is a program support position we built in to a current contract solicitation to help support this work.
- **Travel** – Pending and we can determine once we have a better idea of the proposals from PR and USVI.

I hope you find this information helpful. I will continue to keep you posted as things develop, but try to not overwhelm. DSLR is going to be setting up regular calls and we may reach out to some of you at times to join them, if appropriate.

If you ever have any questions about the status of any of these activities, please do not hesitate to reach out.

Thank you!

Joni

Joni C. Young
Deputy Director
Division of Violence Prevention
NCIPC, CDC
Office: 770-488-1378
Blackberry: 404-247-0949
JYoung@cdc.gov

I telework on Mon/Thur and can be reached by email or blackberry.

From: McIntosh, Wendy LiKamWa (CDC/ONDIEH/NCIPC)
Sent: 28 Jun 2018 14:46:48 -0400
To: Herbst, Jeffrey (CDC/ONDIEH/NCIPC);Bartholow, Brad (CDC/ONDIEH/NCIPC);Williams, Holly A. (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Trudeau, Aimee T. (CDC/ONDIEH/NCIPC);Lokey, Colby N. (CDC/ONDIEH/NCIPC)
Cc: Peterson, Cora (CDC/ONDIEH/NCIPC)
Subject: RE: URGENT - PLEASE REVIEW: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests

Thanks, Jeff. I'm glad they decided not to release any specifics regarding numbers and rates, given that there's so much uncertainty about what our new results will look like.
Wendy

From: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 2:39 PM
To: Bartholow, Brad (CDC/ONDIEH/NCIPC) ; Williams, Holly A. (CDC/ONDIEH/NCIPC) ; McIntosh, Wendy LiKamWa (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Trudeau, Aimee T. (CDC/ONDIEH/NCIPC) ; Lokey, Colby N. (CDC/ONDIEH/NCIPC)
Cc: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Subject: FW: URGENT - PLEASE REVIEW: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests

Looping you all in. Let me know if you have any questions or concerns. -Jeff

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 2:28 PM
To: Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Holton, Kelly (CDC/OID/NCEZID) <nfh5@cdc.gov>
Subject: RE: URGENT - PLEASE REVIEW: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests

Hi all-
OADC's recommendation for new requests is to not send any of the detailed information and only send this:

Please see below for the MMWR notice about reanalysis of suicide data in an article published in July 2016. CDC is committed to quality and is working to meet our usual standards for excellence. The scientific authors are working diligently to reanalyze and publish corrected data. We apologize for the errors in the report. Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities.

Notice to Readers: Ongoing Analysis of Suicide Rates Data by Occupational Group from Results Reported in *MMWR*

Recently, *MMWR* Editors were informed by the authors of "Suicide Rates by Occupational Group — 17 States, 2012" that some results and conclusions might be inaccurate as a result of coding errors for certain occupational groups. The authors are undertaking a thorough reanalysis of the data. This notice is to alert readers about the coding errors while the reanalysis is conducted to assess the validity of results and conclusions in the publication.

From: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 1:08 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>
Cc: Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>
Subject: URGENT - PLEASE REVIEW: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests

Courtney – The attached revised reactive statement was reviewed and approved by DVP ADS, Policy/Communications and Jim.

Jeff

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 12:59 PM
To: Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Subject: RE: URGENT - PLEASE REVIEW: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests

I concur

From: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 12:38 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>
Cc: Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Subject: FW: URGENT - PLEASE REVIEW: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests

Erin, Marie, Malia & Jim –
Do you concur with the attached edits? I need to get this to Courtney ASAP.
Thanks, Jeff

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 12:35 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Subject: RE: URGENT - PLEASE REVIEW: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests

Hi everyone,
I agree with Erin's point. I think we can shorten it somewhat. I just discussed this with Cory too. I adapted the second line that you provided, Erin, to the version that Cory sent. We think this works well. Do you agree?
-Tom

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 12:20 PM
To: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Subject: RE: URGENT - PLEASE REVIEW: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests

Thanks for drafting Jeff, sorry if I missed it, but weren't we going to add statement to the beginning to say something like "As reflected in the notice to readers CDC is conducting ongoing analysis. The information below reflects our current understanding pending conclusion of the analyses."

From: Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 12:15 PM
To: Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>
Subject: RE: URGENT - PLEASE REVIEW: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests

Hi Jeff,
Thanks for taking step to put this in a word document. Attached are my advised modifications.
Cory

From: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 12:05 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>
Subject: URGENT - PLEASE REVIEW: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests
Importance: High

Cory – Attached is the Word document with track changes.
Tom, Erin, Malia, Marie and Jim – please send me your comments so I can provide the final version to Courtney.
Jeff

From: Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 11:56 AM
To: Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests

Hi Jeff,
Thanks for getting this started. Courtney will need to send up a tracked version for review. Could you please drop this into a word document and track the changes that have been made to the original draft and then circulate that to us? That document will also make it easier for everyone in the division to review quickly. It would also be helpful if you can assist with getting coordinating the review by DVP policy, communication, ADS, and Jim and sending the revised statement up to Courtney once that division review is completed.
Cory

From: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 10:40 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>
Cc: Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: Thurs 6/28/2018 - Revised Reactive Statement: RE: suicide and occupation requests
Importance: High

All – Below is the revised reactive statement per our telephone conversation this morning. Please review and forward to Center et al. –Jeff & Brad

UPDATED reactive statement:

CDC published a Notice to Readers in the June 28, 2018 issue of the Morbidity and Mortality Weekly Report (MMWR) regarding errors detected by the authors of the July 2016 MMWR *Suicide Rates by Occupational Group- 17 States, 2012.* As part of data analyses to publish updated suicide rates by occupation group for years spanning 2005-2015, CDC discovered the following coding issues with the 2016 MMWR findings.

- Farming, Fishing, and Forestry Occupations
    - "Farmers" and "Ranchers" were coded under the occupation category, Farming, Fishing, and Forestry. However, the Bureau of Labor Statistics' Standard Occupation Classification (SOC) system, which is used to assign occupation codes to each suicide death, and the U.S. Census Bureau's Current Population Survey March Supplement classify farmers and ranchers under "Management Occupations." This led to overestimation of the rate of suicide in the Farming, Fishing, and Forestry group and underestimation of the rate of suicide among Managers.
- Food Preparation and Serving Related Occupations
    - Restaurant managers/owners were coded under the "Food Preparation and Serving Related" occupational group, however these cases should have been coded under "Management Occupations." This led to an overestimation of the rate of suicides among the food preparation group and an underestimation of manager suicides
- Management Occupations
    - Because of misclassification under Farming, Fishing, and Forestry and Food Preparation and Serving Related occupations, rates within the Management occupations category will also change.
- Computer and Mathematical Occupations
    - An error was made during data analyses in which occupations with any title containing the letters "IT" in succession, (e.g., wrITer, archITect) were miscoded under the "Computer and Mathematical Occupations" group. This led to suicide rates among computer and mathematical occupations being overestimated and other groups being underestimated.

Research shows that suicide is one of the top 10 leading causes of death in the United States. Suicide rates are higher in rural America than in urban America. Additionally, the gap in suicide rates between rural and urban areas grew steadily from 1999 to 2015. Individuals living and working in rural communities are at higher risk of suicide regardless of their occupation. Comprehensive suicide prevention efforts, such as those found in CDC's *Preventing Suicide: A Technical Package of Policy, Programs and Practices*, can benefit people living in rural America.

CDC is committed to quality and is working to meet our usual standards for excellence. CDC's MMWR office is publishing a Notice to Readers on Thursday, June 28, and the scientific authors are working

diligently to reanalyze and publish corrected data. We apologize for the errors in the report. Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities.

Notice to Readers: Ongoing Analysis of Suicide Rates Data by Occupational Group from Results Reported in *MMWR*

Recently, *MMWR* Editors were informed by the authors of "Suicide Rates by Occupational Group — 17 States, 2012" (*1*) that some results and conclusions might be inaccurate as a result of coding errors for certain occupational groups. The authors are undertaking a thorough reanalysis of the data. This notice is to alert readers about the coding errors while the reanalysis is conducted to assess the validity of results and conclusions in the publication.

Reference

1. McIntosh WL, Spies E, Stone DM, Lokey CN, Trudeau AR, Bartholow B. Suicide rates by occupational group—17 states, 2012. MMWR Morb Mortal Wkly Rep 2016;65:641–5. https://doi.org/10.15585/mmwr.mm6525a1

From: Ballman, Marie R. (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 28, 2018 9:06 AM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Holton, Kelly (CDC/OID/NCEZID) <nfh5@cdc.gov>; Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>
Subject: ACTION Needed: RE: suicide and occupation requests
Importance: High

Tom, Cory, and I just chatted. We need a meeting of DVP in consultation with Courtney this morning. Can I put something on the calendar for 9:30 or 10 am?
Can Courtney, Cory, Tom, Brad, Jeff, Erin, and Malia make this work? (Malia may not be able to join because she is in training.)
Thanks,
Marie

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 27, 2018 6:43 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC)

<dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Holton, Kelly (CDC/OID/NCEZID) <nfh5@cdc.gov>; Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>
Subject: RE: suicide and occupation requests

Hi there,

This is what OADC leadership is proposing, if everyone is ok with this it will need to be re-cleared through HHS. I will then need to contact the other reporters who received the previous statement and give them the updated statement.

Thanks!

Courtney

In July 2016 CDC published a Morbidity and Mortality Weekly Report (MMWR), *Suicide Rates by Occupational Group- 17 States, 2012.* As part of data analyses to publish updated suicide rates by occupation group for years spanning 2005-2015, CDC discovered the following coding issues with the 2016 MMWR findings.

- Farming, Fishing, and Forestry Occupations
    - ~~o~~ "Farmers" and "Ranchers" were coded under the occupation category, Farming, Fishing, and Forestry. However, the Bureau of Labor Statistics' Standard Occupation Classification (SOC) system, which is used to assign occupation codes to each suicide death, and the U.S. Census Bureau's Current Population Survey March Supplement classify farmers and ranchers under "Management Occupations." This led to overestimation of the rate of suicide in the Farming, Fishing, and Forestry group and underestimation of the rate of suicide among Managers. We are working now to determine how this affected the results reported in the article.
- Food Preparation and Serving Related Occupations
    - ~~o~~ Restaurant managers/owners were coded under the "Food Preparation and Serving Related" occupational group, however these cases should have been coded under "Management Occupations." We are working now to understand how this affected the results reported in the article. ~~This led to an overestimation of the rate of suicides among the food preparation group and an underestimation of manager suicides.~~
- Management Occupations
    - Because of misclassification under Farming, Fishing, and Forestry and Food Preparation and Serving Related occupations, rates within the Management occupations category ~~will also~~ are expected to change.
- Computer and Mathematical Occupations
    - A coding error was made during data analyses that led to some cases being mistakenly included in this category. We are working now to understand how this affected the results reported in the article. ~~As a result, the suicide rates were~~

~~overestimated for computer and mathematical occupations and underestimated among other groups.~~

Research shows that suicide is one of the top 10 leading causes of death in the United States. Suicide rates are higher in rural America than in urban America. Additionally, the gap in suicide rates between rural and urban areas grew steadily from 1999 to 2015. Individuals living and working in rural communities are at higher risk of suicide regardless of their occupation. Comprehensive suicide prevention efforts, such as those found in CDC's *Preventing Suicide: A Technical Package of Policy, Programs and Practices*, can benefit people living in rural America.

CDC is committed to quality and is working to meet our usual standards for excellence. CDC's MMWR office published a Notice to Readers on Thursday, June 28, and the scientific authors are working diligently to reanalyze and publish corrected data. We apologize for any misrepresentation. Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 27, 2018 5:41 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Holton, Kelly (CDC/OID/NCEZID) <nfh5@cdc.gov>; Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>
Subject: RE: suicide and occupation requests

Hi Courtney,

Here is the edited text describing the coding errors that we had drafted for the talking points. You will see that this shortens the responses to the first and fourth bullets. This change is suggested in case the results change as the team finalizes the updated numbers.

-Tom

While in the process of updating occupational suicide rates to reflect data from 2005-2015 in preparation for a new report, CDC discovered several coding errors from the 2016 report.

- *Farming, Fishing, and Forestry Occupations*
  - "Farmers" and "Ranchers" were coded under the occupation category, Farming, Fishing, and Forestry. However, the SOC system, which is used to assign occupation codes to each suicide death, and the U.S. Census Bureau's Current Population Survey March Supplement classify farmers and ranchers under "Management Occupations." This led to overestimation of the rate of suicide in the Farming, Fishing, and Forestry group and underestimation of the rate of suicide among Managers.
- Food Preparation and Serving Related Occupations
  - Restaurant managers/owners were coded under the "Food Preparation and Serving Related" occupational group, however these cases should have been coded

under "Management Occupations." This led to an overestimation of the rate of suicides among the food preparation group and an underestimation of manager suicides

- Management Occupations
  - Because of misclassification under Farming, Fishing, and Forestry and Food Preparation and Serving Related occupations, rates within the Management occupations category will also change.
- Computer and Mathematical Occupations
  - A coding error was made during data analyses that led to some cases mistakenly included in this category. As a result, the suicide rates among computer and mathematical occupations were overestimated, and they underestimated among other groups.

- CDC is undertaking a thorough reanalysis of the data and conclusions in the publication. Revised information will be made available as soon as possible.

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 27, 2018 4:16 PM
To: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Holton, Kelly (CDC/OID/NCEZID) <nfh5@cdc.gov>; Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>
Subject: RE: suicide and occupation requests

The attached has gone out to CDC's media list, embargoed until 1:00 pm tomorrow.
Sorry to push, but we need to figure out the statement because we likely will be getting more requests. I already have one from Politico. Is it just the green highlight that needs to be removed or will there be more changes?
Thanks much!
Courtney

From: Bartholow, Brad (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 27, 2018 3:27 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>

Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Holton, Kelly (CDC/OID/NCEZID) <nfh5@cdc.gov>; Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>
Subject: RE: suicide and occupation requests

Hi Courtney,

I agree with Tom and Cory that we should not include any numeric details until such time that all data coding and calculations have been verified. With regard to the question about extracting data specific to farmers or agricultural workers from the group in the larger category, we are not able to do that because we don't have the specific denominator data.

Thanks,

Brad

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 27, 2018 2:55 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Holton, Kelly (CDC/OID/NCEZID) <nfh5@cdc.gov>; Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>
Subject: RE: suicide and occupation requests

Thanks all!

Brad, please let me know if you need any clarification on what the CBS reporter is asking, appreciate your guidance with drafting a response back to her. Also, so you are aware, the original statement went out last Friday to New Food Economy and Washington Post. Today, the updated statement went to Scripps, KRLD, Australian Broadcasting Company, Emmetsburg Reporter & Democrat and CBS—that includes the green highlight below. Once there is another updated version I will need to share with OADC and HHS again for approval.

Thanks!

Courtney

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 27, 2018 2:49 PM
To: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Richmond-Crum, Malia

(CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Holton, Kelly (CDC/OID/NCEZID) <nfh5@cdc.gov>; Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>
Subject: RE: suicide and occupation requests

Hi everyone,

I agree, until the new results have been confirmed and double checked with NIOSH I would prefer that we not release details. In addition to the highlighted text below, I think we should simplify the response about the compute/mathematical occupation.

I know Cory is working on edits to the larger talking point document that this is drawn from so I'll send her my edits to incorporate in that.

-Tom

From: Ferdon, Corinne (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 27, 2018 2:28 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Holton, Kelly (CDC/OID/NCEZID) <nfh5@cdc.gov>; Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>
Subject: RE: suicide and occupation requests

Courtney: I am currently reviewing another Q/A document in clearance and I am noticing what I have highlighted in green below. I thought we had decided to not include this type of information until the re-analyses are completed and review. It would be best for Brad to validate if this point should be included at this point in time. I may not be current on all conversations.

Brad: Could you verify if this information should be included at this time or are we completely confident that this information is accurate and will not change over the course of further re-analyses?

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 27, 2018 10:22 AM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Middlebrooks, Jennifer (CDC/ONDIEH/NCIPC) <jod5@cdc.gov>; Holton, Kelly (CDC/OID/NCEZID)

<nfh5@cdc.gov>; Eschelbach, Julie (CDC/ONDIEH/NCIPC) <hsa7@cdc.gov>; Lane, Gabraelle (CDC/ONDIEH/NCIPC) <xkp4@cdc.gov>; Solhtalab, Elizabeth (CDC/ONDIEH/NCIPC) <ikd9@cdc.gov>; Watkins, Jacqueline (CDC/OID/NCEZID) <gnt2@cdc.gov>

Subject: suicide and occupation requests

Good morning all,

Just so we are all on the same page, there are four pending requests around the suicide/occupation MMWR. Austrailian Broadcasting Corporation, Scripps News, KRLD News, and Emmetsburg Reporter & Democrat. I will share the reactive statement (once we have HHS approval), which has been updated to include the mention of a Notice to Readers. I will also share with CBS so they are aware, they did not reach out before writing their story. The CBS piece is likely the reason some of the requests below came in. I've included the updated reactive statement at the bottom, as well as the final Notice to Readers just so everything is in one email.

Thanks all for your help with this!

Courtney

Reporter's Name: Marty McCarthy

Media Outlet: Australian Broadcasting Company

Questions for CDC: Hi Dante Sorry, I sent you an email from the wrong account. Please reply to this one. Thanks for taking my call earlier. I was hoping to interview someone over the phone sometime in the next few hours, about the rising suicides rates in the US agriculture sector. Here in Australia we have a similar problem. I work the Australian Broadcasting Corporation. The story will be for radio and online. If you're keen, please let me know who I should call and a contact number for them. Regards,

---

Reporter's Name: Patrick Terpstra

Media Outlet: Scripps News

Questions for CDC: Hi there, Patrick with the DC bureau of Scripps News working with a deadline today of 5 ET. I hope this finds you well. I've got some questions on this study, "Suicide Rates by Occupational Group - 17 states, 2012." 1) Is this the most recent analysis of suicide rates that would include "healthcare pracitioners and technical" (SOC code 29)? 2) Is CDC able to break down the suicides in SOC code 29 to include just numbers in SOC code 29-1060, "physicians and surgeons," which comprises: . 29-1061 Anesthesiologists . 29-1062 Family and General Practitioners . 29-1063 Internists, General . 29-1064 Obstetricians and Gynecologists . 29-1065 Pediatricians, General . 29-1066 Psychiatrists . 29-1067 Surgeons . 29-1069 Physicians and Surgeons, All Other I can also be reached at 202.408.2709. Thanks! Patrick

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Reporter's Name: Cameron Fairchild

Media Outlet: KRLD News

Questions for CDC: I am reading the CDC report on a huge spike in suicides among farmers and farm workers. I would like to do a brief telephone interview on the study. In addition to our normal Texas State Network newscasts, we have a daily Lone Star Farm and Ranch Report for our stations. I will do a feature for that show.

Reporter's Name: Darren Fraser

Media Outlet: Emmetsburg Reporter & Democrat

Questions for CDC: Dear CDC Media: Please send me a link to the above report. Thank you. Sincerely,

UPDATED reactive statement:

In July 2016 CDC published a Morbidity and Mortality Weekly Report (MMWR), *Suicide Rates by Occupational Group- 17 States, 2012.* As part of data analyses to publish updated suicide rates by occupation group for years spanning 2005-2015, CDC discovered the following coding issues with the 2016 MMWR findings.

- Farming, Fishing, and Forestry Occupations
    - "Farmers" and "Ranchers" were coded under the occupation category, Farming, Fishing, and Forestry. However, the Bureau of Labor Statistics' Standard Occupation Classification (SOC) system, which is used to assign occupation codes to each suicide death, and the U.S. Census Bureau's Current Population Survey March Supplement classify farmers and ranchers under "Management Occupations." This led to overestimation of the rate of suicide in the Farming, Fishing, and Forestry group and underestimation of the rate of suicide among Managers. This affected 90 cases analyzed in the study. This revised rate ranks the Farming, Fishing, and Forestry occupational group as having the third highest suicide rate (originally it was reported as the highest), after the "construction and extraction" and the "installation, maintenance, and repair" occupational groups.
- Food Preparation and Serving Related Occupations
    - Restaurant managers/owners were coded under the "Food Preparation and Serving Related" occupational group, however these cases should have been coded under "Management Occupations." This led to an overestimation of the rate of suicides among the food preparation group and an underestimation of manager suicides
- Management Occupations
    - Because of misclassification under Farming, Fishing, and Forestry and Food Preparation and Serving Related occupations, rates within the Management occupations category will also change.
- Computer and Mathematical Occupations
    - An error was made during data analyses in which occupations with any title containing the letters "IT" in succession, (e.g., wrITer, archITect) were miscoded under the "Computer and Mathematical Occupations" group. This led to suicide rates among computer and mathematical occupations being overestimated and other groups being underestimated.

Research shows that suicide is one of the top 10 leading causes of death in the United States. Suicide rates are higher in rural America than in urban America. Additionally, the gap in suicide rates between rural and urban areas grew steadily from 1999 to 2015. Individuals living and working in rural communities are at higher risk of suicide regardless of their occupation. Comprehensive suicide prevention efforts, such as those found in CDC's *Preventing Suicide: A Technical Package of Policy, Programs and Practices*, can benefit people living in rural America.

CDC is committed to quality and is working to meet our usual standards for excellence. CDC's MMWR office is publishing a Notice to Readers on Thursday, June 28, and the scientific authors are working diligently to reanalyze and publish corrected data. We apologize for any misrepresentation. Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities.

Notice to Readers: Ongoing Analysis of Suicide Rates Data by Occupational Group from Results Reported in *MMWR*

Recently, *MMWR* Editors were informed by the authors of "Suicide Rates by Occupational Group — 17 States, 2012" (*1*) that some results and conclusions might be inaccurate as a result of coding errors for certain occupational groups. The authors are undertaking a thorough reanalysis of the data. This notice is to alert readers about the coding errors while the reanalysis is conducted to assess the validity of results and conclusions in the publication.

Reference

1. McIntosh WL, Spies E, Stone DM, Lokey CN, Trudeau AR, Bartholow B. Suicide rates by occupational group—17 states, 2012. MMWR Morb Mortal Wkly Rep 2016;65:641–5. https://doi.org/10.15585/mmwr.mm6525a1

Courtney N. Lenard, MA
Senior Press Officer| National Center for Injury Prevention and Control | Health Communication and Science Office | O: 770.488.3733 | Monday & Friday telework: 404.808.3037

CDC's Injury Center
Preventing Injuries and Violence Through Science and Action

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: 9 May 2018 11:24:28 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: veteran suicide

Hi Tom,
Unfortunately, the degree in which state suicide rate increases is attributable to Veteran suicide rate increases is unknown at this point. Rob Bossarte and I are working on this paper right now (Rob is lead). We may have some preliminary findings but we are hesitant to release anything at this point because we need to coordinate any possible public release of these findings with the release of the VA suicide report, which should be released soon.
The best I can tell you is to say something "Currently, it is not well known of how much the state rate increases are attributable to Veteran suicide rate increases. CDC is currently working with academic scholars and the Department of Veterans Affairs to examine that specific question. Results of this work is forthcoming."
Does the OD have a preference on how we should release our findings (peer-reviewed paper, MMWR)? If they want us to release the findings really soon as a follow-up to this Vital Signs, then we can do an MMWR for Suicide Prevention Month. Thoughts?
J.

J. Logan, Ph.D.
Suicide and Youth Violence, Emerging Topics (SaYVE) Team
Research & Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
MS: F-63
Email: ffa3@cdc.gov
Telework day: Thursday
Office phone: 770-488-1529
Telework phone: 404-884-4879

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 9, 2018 9:07 AM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: veteran suicide

Hi J.,
Thank you for providing these. The need for this type of information came up yesterday.
We will be adding some to the Q's and A's.
Dr. Shuchat expressed interested in understanding how much of the population increase in suicide rates is attributable to the increase among veterans. How well are we able to quantify this?
-Tom

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 8, 2018 12:13 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: veteran suicide

Here are some TPs on Military and Veteran suicide. With regard to the epi, I didn't know what was important so I included a number of bullet points. Feel free to select the most important ones for Anne. More information can also be accessed on SharePoint/SDVWG/documents..

I had a couple minor points or questions that might come up in general. Feel free to add to your talking points.

J. Logan, Ph.D.
Suicide and Youth Violence, Emerging Topics (SaYVE) Team
Research & Evaluation Branch
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National Center for Injury Prevention and Control
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MS: F-63
Email: ffa3@cdc.gov
Telework day: Thursday
Office phone: 770-488-1529
Telework phone: 404-884-4879

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Saturday, May 5, 2018 12:58 PM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
Subject: RE: veteran suicide

Hi J.,

The VS MMWR (attached) is not about military/Veteran Suicide but there is one line in the table showing the proportion of decedents who have served in the military (see Table 1).

The Surgeon General is going to participate in the telebriefing for the VS and he is likely to make a point about the high risk among Veterans and the need for prevention. This could generate some questions for us from the media.

I'm glad that you have q's and a's to choose from. I don't seem to be able to access the Q's and A's on Sharepoint. If you could send us a few Q's and A's with short answers to questions you think will come up related to trends, prevention strategies, what CDC is doing, etc. that will be helpful. You have a better sense of what comes up most often.

We have a pre-briefing with Dr. Schuchat on Tuesday and, if possible, it would be good for us to have these with us in case it comes up. The actual launch is not until 6/7 though so we have time to finalize this once we see exactly what the SG intends to say.

Thank you!

-Tom

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: Saturday, May 5, 2018 9:15 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: veteran suicide

Hi Tom,

If you can give me a few days, I can help. If you need the Q and As immediately, then feel free to draw from the documents I posted on SharePoint. Just note, on Monday morning, I plan to update them in prep for Marcus so please wait on accessing them until noonish. We've had some significant enhancements that I need to include. All I ask is that if you can please send the Q and As to me before sending them up the chain, I would appreciate it. I just want to keep an eye on what we release so we don't accidently repeat the events of the last few weeks.

If you would like my help with drafting them, then please send me any background materials (Vital Signs drafts, fact sheets etc) so I understand the context. There are a lot of different ways the Q and As can go and so I might be able to narrow the scope of possible key relevant questions and messages if I have more background.

J.

J. Logan, Ph.D.
Suicide and Youth Violence, Emerging Topics (SaYVE) Team

Research & Evaluation Branch
Division of Violence Prevention
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Centers for Disease Control and Prevention
MS: F-63
Email: ffa3@cdc.gov
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Office phone: 770-488-1529
Telework phone: 404-884-4879

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 4, 2018 11:54 AM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: veteran suicide

Hi J.,
We are compiling q's and a's for the upcoming vital signs. Do you have any q's and a's related to Veteran suicide that we can pull from?
The Surgeon General is participating in the launch and he is particularly interested in Veteran suicide.
I think short answers to questions about trends, prevention strategies, and what CDC is doing will be helpful.
Thank you!
-Tom

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: 8 May 2018 12:13:03 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: veteran suicide
Attachments: TPs_mil_Logan.docx

Here are some TPs on Military and Veteran suicide. With regard to the epi, I didn't know what was important so I included a number of bullet points. Feel free to select the most important ones for Anne. More information can also be accessed on SharePoint/SDVWG/documents..
I had a couple minor points or questions that might come up in general. Feel free to add to your talking points.

J. Logan, Ph.D.
Suicide and Youth Violence, Emerging Topics (SaYVE) Team
Research & Evaluation Branch
Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
MS: F-63
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Telework day: Thursday
Office phone: 770-488-1529
Telework phone: 404-884-4879

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Saturday, May 5, 2018 12:58 PM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Subject: RE: veteran suicide

Hi J.,
The VS MMWR (attached) is not about military/Veteran Suicide but there is one line in the table showing the proportion of decedents who have served in the military (see Table 1).
The Surgeon General is going to participate in the telebriefing for the VS and he is likely to make a point about the high risk among Veterans and the need for prevention. This could generate some questions for us from the media.
I'm glad that you have q's and a's to choose from. I don't seem to be able to access the Q's and A's on Sharepoint. If you could send us a few Q's and A's with short answers to questions you think will come up related to trends, prevention strategies, what CDC is doing, etc. that will be helpful. You have a better sense of what comes up most often.
We have a pre-briefing with Dr. Schuchat on Tuesday and, if possible, it would be good for us to have these with us in case it comes up. The actual launch is not until 6/7 though so we have time to finalize this once we see exactly what the SG intends to say.
Thank you!
-Tom

From: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC)
Sent: Saturday, May 5, 2018 9:15 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: veteran suicide

Hi Tom,
If you can give me a few days, I can help. If you need the Q and As immediately, then feel free to draw from the documents I posted on SharePoint. Just note, on Monday morning, I plan to update them in

prep for Marcus so please wait on accessing them until noonish. We've had some significant enhancements that I need to include. All I ask is that if you can please send the Q and As to me before sending them up the chain, I would appreciate it. I just want to keep an eye on what we release so we don't accidently repeat the events of the last few weeks.

If you would like my help with drafting them, then please send me any background materials (Vital Signs drafts, fact sheets etc) so I understand the context. There are a lot of different ways the Q and As can go and so I might be able to narrow the scope of possible key relevant questions and messages if I have more background.

J.

J. Logan, Ph.D.
Suicide and Youth Violence, Emerging Topics (SaYVE) Team
Research & Evaluation Branch
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Centers for Disease Control and Prevention
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Telework day: Thursday
Office phone: 770-488-1529
Telework phone: 404-884-4879

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Friday, May 4, 2018 11:54 AM
To: Logan, Joseph (J.) (CDC/ONDIEH/NCIPC) <ffa3@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: veteran suicide

Hi J.,

We are compiling q's and a's for the upcoming vital signs. Do you have any q's and a's related to Veteran suicide that we can pull from?

The Surgeon General is participating in the launch and he is particularly interested in Veteran suicide.

I think short answers to questions about trends, prevention strategies, and what CDC is doing will be helpful.

Thank you!

-Tom

1. ***Do you have any information on suicide among Veterans and Military service members?***

While we did not describe Veteran suicides in this study, here are some key epidemiologic findings from other reports published by the Departments of Veterans Affairs and Defense, as well as the CDC

Veterans:

- An average of 20 Veterans died by suicide each day; roughly 14 of these are not using VHA services.
- Rates dramatically increased from 12/100,000 in 2005 to 110/100,000 in 2014 among young Veterans aged 18-24 years who were using VHA services and were in Operations Enduring Freedom, Iraqi Freedom, or New dawn
- Suicides among young Veterans aged 18-35 years are highly concentrated in a small proportion of counties. Within 17 NVDRS states, an estimated 33% of suicides among Veterans aged 18-35 years occurred in just 3% of U.S. counties and 69% occurred in 13% of U.S. counties. Many of these high burden counties do not have easy access to VHA facilities.
- The overall burden of Veteran suicide is mostly among Veterans of middle to older adult ages. An estimated 65% of Veteran suicides occurred among Veterans ages 50 years an older
- Veterans accounted for 18 percent of adult suicides but constituted only 8.5 percent of the U.S. adult population (ages 18+).
- Accounting for age and sex, risk for suicide was 21 percent higher among Veterans versus civilians.
- Accounting for age, risk for suicide was 2.4 times higher among female Veterans versus female civilians

Active duty:

- Suicide rates have doubled from 12.5 per 100,000 in 2005 to 30 deaths per 100,000 in 2012. Steady declines in recent years have been observed (although this could be because more service members were recently discharged and therefore their suicides would be reflected in the Veteran population)
- Since 2001-2014, 51% of suicide decedents were Army service members; 18% were Air Force service members; 17% were Navy service members; 14% were Marines
- Key epidemiological findings include:
    - 94% were male
    - 72% were of white race
    - 87% were of non-Hispanic ethnicity
    - 83% were under the age of 35 years
    - 88% were in the enlisted ranks of E1-E9
    - 72% only had a high school graduate level of education (or less)
    - 52% were married
    - 68% of suicides were the result of firearm injuries
    - 54% had a history of deployment

2. ***You mentioned that the veteran suicide rate is increasing among young Veterans and Veterans overall account for 18% of the suicides but only 8.5% of the US adult population, Do you think the rate increases across the states is the result of increases in Veteran suicides?***

For this study, we were unable to explore the reasons of why we observed all of these state increases. This question needs further exploration. Therefore, we are unable to determine if the broad increase in suicide rates across the states is the result of increases in the Veteran suicide rate.

3. ***Is CDC engaged in preventing suicides among Military service members and Veterans?***

CDC has partnered with the Departments of Veterans Affairs and Defense on numerous innovative suicide prevention projects to help address and prevent suicide among active duty service members and Veterans. The innovations span across public health service. Such efforts are focused to improve surveillance of suicide, increase understanding of the antecedents of suicide and potential factors that might protect against risk of suicide, improve early identification of suicide risk and rapid response to those in need of services, and evaluate key population-level suicide prevention policies and strategies being implemented across states and at military installations. While we cannot share details of these efforts at this time, the overall portfolio of work embraces the seven key approaches to prevent suicide as outlined in the CDC's technical package.

Just a few comments on some items that might draw attention:

- Despite the limitation you present, you might still say X% were identified as having a known MH problem by investigating agents and not say X% had "known mental health problems." More studies are coming out with drastically higher prevalence estimates of suicide decedents with known MH problems and decedents who disclose intent. You state the key reasons for why the NVDRS estimates are conservative in the limitations section but readers might not fully understand the language in the text within the context of the limitations. The findings on current/former military service members are particularly conservative. Also the biases in the investigation process may partially account for some of your findings on patterns associated with known MH problems. Agents are notorious for not asking detailed questions while investigating violent deaths among minorities, which may partially account for the higher minority % among those without a 'known MH problem."

- "suicide prevention is often oriented toward downstream identification of suicidal persons, treatment of mental health problems and prevention of reattempts." Many will argue this is not the case anymore. The predictive analytics movement is identifying, or trying to identify, those at risk of suicide and refer such individuals into preventive medicine way before they are exhibiting symptoms, MH problems, or even risk factors. Some will say this is the best way to identify those at risk of suicide who currently do not have known MH problems. This movement is popular and viewed as highly upstream. That is the strength of predictive analytics (i.e., it is moving clinical interventions upstream). The limitations of this clinical upstream strategy are that it benefits those who are in health systems (not the uninsured) and that this type of intervention only reaches the individual-level factors (the real true weakness). Also, many MH systems are already at full capacity and so there is question of whether clinical operations can handle all the preventive individual-level interventions. Therefore, public health strategies that address

factors on the outer layers of the social-ecology, strengthen relationships, build community and community-based suicide prevention efforts, and improve environments will help reduce suicide among populations so clinical operation can focus on getting future high risk patients into preventive interventions before symptoms occur.

- "assuring safe reporting by the media in order to prevent suicide contagion" – One lesson learned from previous high profile Vita Signs that include DHHS or surgeon general messaging is that we lose control of the media coverage. There can easily be 200-300 media reports. Because this VS is presenting on rate increases, media outlets might be prone to reporting this as a "nationwide epidemic," We know that such terms are inflammatory and can increase social contagion. One may ask you if you have strong plans to ensure the widespread media coverage will be in compliance with media reporting guidelines.
-

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 14 May 2018 13:55:25 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief
Attachments: TELEBRIEF SCRIPT_V4_pgm_LS_5.7.18_1.40pm_TS_LS_SO.5.11.18.EB+ac+EB ds +EB ds 5.14.2018.docx

Hi Erin and Deb,
I really like the additions that Deb provided. I noticed that we were missing "committed" for the list of terms so I added that and I found one place where we needed to change problems to conditions.

-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 12:53 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief
With attachment!
Hi Erin,
I noted a couple of typos due to tracked changes, a couple of places where problem wasn't replaced with condition and a few other minor things that are corrected.
Thanks!
Deb

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 12:37 PM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief
Attached is the current version of the script. Thank you Deb, Tom and Alex for your feedback. I am waiting to receive revisions from the SG's office on Dr. Adam's part and then will send back to the VS office. Please let me know if anyone has any additional feedback.

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 10:16 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: Re: Vital Signs FS and press release with modifications after the Pre-Brief

Greetings:

I reviewed the transcript, it looks good.

Alex C

Sent from my BlackBerry 10 smartphone.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Sunday, May 13, 2018 19:33
To: Simon, Thomas (CDC/ONDIEH/NCIPC); Black, Erin (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC); Kegler, Scott R. (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Yuan, Keming (CDC/ONDIEH/NCIPC); Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Ballman, Marie R. (CDC/ONDIEH/NCIPC); Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

Thanks, Tom. This looks great. I've gone through and made some additional final edits. Tom and Alex, you may want to take one more look—sorry!

Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Sunday, May 13, 2018 4:49 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

Hi Erin,

Thank you for moving this forward. I suggested a few edits in the version attached. There are some additional points to make in the terms box at the top that I pulled from the definitions document. Deb, I added a note for you. Also, are there any other key points that you want to be sure are made?

Erin, in the summary you provided about next steps you indicated that there was a request to put the % who disclosed suicidal thoughts in the script. Was that really to go in the script? It seems more appropriate for the Q & A.

The answer would be that the % of suicide decedents who disclosed suicide intent was slightly higher among those with mental health problems (24.5%) compared to those without known mental health problems (22.5%).

-Tom

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Saturday, May 12, 2018 12:01 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

Thanks Alex. I made your suggested edits in the attached. I also spoke to Tom and we decided to add the terminology guidance box and Air Force example. I did not add mention of the HP2020 goal, the % of people who told someone they were contemplating suicide or mention CDR Cunningham (since it hasn't been reported as a suicide I don' think we should proactively discuss during a suicide VS release) rather add a TP to the Q&As incase a question is asked. Please let me know what you all think.

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 6:15 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: Re: Vital Signs FS and press release with modifications after the Pre-Brief

Greetings:
I have attached my comments. Pretty minor just some word choices.
Alex C
Sent from my BlackBerry 10 smartphone.

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 15:18
To: Simon, Thomas (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC); Kegler, Scott R. (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Yuan, Keming (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC); Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Ballman, Marie R. (CDC/ONDIEH/NCIPC); Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

All – wanted to get your thoughts on the script for Dr. S.
In working through the document, I made these updates:

- Updated the headlines based on comments today.
- Added a reference to thank congress for funding to expand NVDRS.
- Removed the reference to 'suicide care'.
- Added reference to age-specific rates overtime (but not the other sited work mentioned)

- Added percent of those that died by suicide who were military/vets (It seems weird to specifically call this out in the script but per Anne's request, let me know your thoughts).

Let me know your thoughts about the following that were discussed in the pre-brief– I think these are more appropriate in the Q&As than the script:

- Terminology guidance box – Added to the script
- HP2020 goal
- Air force example – Added to the script
- % of people who told someone they were contemplating suicide
- Mention of CDR Cunningham (I don't think it is confirmed he died by suicide, rather drowning)

Current version of the script is attached, let me know what you think. I hope to send to Leslie to take a quick look before sending back to the VS office COB Monday. Still waiting for edits from the SG's office on his piece – I sent them a reminder.

E

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 10, 2018 6:00 PM
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: Vital Signs FS and press release with modifications after the Pre-Brief

Hi VS team,

We really appreciated all the helpful feedback provided during the pre-brief with Dr. Schuchat. We also appreciate the guidance you provided before and after. The ideas that the graphics team provided for page 3 during the call yesterday seem like they will be helpful. We look forward to seeing the new version.

We are attaching a copy of the fact sheet pdf with embedded stickies to describe specific edits. These reflect the changes we discussed during and after the pre-brief. I'm also attaching a Word document that describes the changes that we discussed for page 3 during the call yesterday. We are providing shortened text for the figure that was at the top of page 3. I understand that this will be formatted using the new layout but we edited the text in the old format so you can see how it relates. Please use this new text. This document also provides the 5 steps to go on the bottom right of page 3 and some other specific edits to the title and warning signs text.

We are also attaching the press release with a few edits. We were reflecting on Dr. Schuchat's concern about small states and whether the increase could be based on a small number of suicides. Scott looked into this for us and we are comfortable that these are meaningful increases. He prepared a helpful Q & A about this (attached). Given this, we think it is ok to keep the text in the press release about the ranges across states. I wanted to mention this to you though in case you want to consult with Dr. Schuchat about this given the questions she raised.

Finally, regarding the request to reflect how the increases in suicide rates have varied across age group, we are proposing the addition of the following highlighted text to the introductory paragraph. Can you please check to see if this is consistent with what Dr. Schuchat would like?

BACKGROUND AND PURPOSE

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (1). Between 1999 and 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (2,3). Suicide rates have increased among all age groups younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14 (3). Suicide is the 10th leading cause of death and is one of just three leading causes that are increasing (1,4). Additionally, rates of emergency department visits for nonfatal self-harm, a key risk factor for suicide, increased 42% between 2001 and 2015 (1). Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs (1).

Thank you!

Tom, Deb, and our VS team

Review Tracker

- NCIPC OC Leslie Dorigo: 4/25/18
- DVP ADS Tom Simon: 4/24/18
- DVP Policy Malia Richmond-Crum: 4/23/18
- DVP SME Deb Stone: 4/19/18, 4/24/18, 5/13
- DVP HCET Marie Ballman: 4/17/2018
- LS-OADC: 5/1/2018
- KSG-OADC: 5/4/2018

Suicide Terminology	
Don't Do This	**Do This Instead**
Don't use sensationalistic headlines (e.g., Kurt Cobain used shotgun to commit suicide)	Do inform without sensationalizing (e.g. Curt Cobain dead at 27)
Don't describe suicide as an epidemic, skyrocketing, etc.	Do use the most recent CDC data and non-sensational words (rise, higher, etc.)
Don't describe suicide as inexplicable or "without warning"	Do include the 'warning signs' and 'what to do' info in articles
Don't refer to suicides or attempts as 'successful' or 'completed'	Describe as suicide, person died by suicide, or life lost to suicide
Don't refer to suicide attempts as 'unsuccessful,' 'failed attempt' or 'nonfatal suicide'	Describe as 'suicide attempt' or 'suicidal self-directed violence'
Don't use 'committed' suicide because this invokes the idea of a crime	Describe as died by suicide

Vital Signs Rising Suicide Rates Across U.S.

June 7, 2018

Desired Headlines

- Nearly 45,000 lives lost to suicide~~s occurred~~ in 2016, but suicide is preventable.
- Suicide rates ~~going~~ up in almost all states, but suicide is preventable.
- Suicide rates ~~s increased~~ went up more than 30% in half of U.S. states between 1999 and 2016.
- Many factors contribute to suicide, beyond mental health conditions ~~problems~~ alone ~~contribute to~~

Moderator: Thank you (OPERATOR NAME). And thank you all for joining us today for the release of a new CDC Vital Signs report, ~~this one~~ on ~~Circumstances and~~ Trends in State Suicide Rates and contributing circumstances to suicide. We are joined by Dr.

Anne Schuchat, CDC's Principal Deputy Director and the Surgeon General Dr. Jerome Adams. Dr. Deb Stone, ~~one of the~~lead author~~s~~ of the study, is also available to help ~~with~~answer questions. Following remarks, we will respond to questions. I'd like to turn the call over now to Dr. Anne Schuchat.

Dr. Schuchat:

- Good afternoon and thank you for joining us today.
- CDC works 24/7 to protect Americans against health threats. Each month in CDC's *Vital Signs* report, **we focus on one of these threats – and what can be done about it**.
- Today's report contains ~~alarming~~ **new information about state suicide trends, and the range of factors that contribute to ~~it~~suicide.**
- In 2016 alone, **45,000 people in the U.S. lost their lives to suicide.**
- **Suicide rates have increased among all age groups** younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14.
- W~~hat w~~e found ~~is~~ that **suicide rates have increased in nearly every state** across the nation – and suicide is ~~it's~~ one of just three leading causes of death that are on the rise.

Comment [ST(]: Suggest moving this up since it is not a key finding from this report.

- ~~**Rates increased among all age groups** younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14.~~
- ~~**These are devastating findings are unacceptable.** We know that every~~Ssuicide greatly ~~is a tragedy for those individuals, their~~impacts families, friends, ~~and~~ colleagues, and entire communities. **These findings are unacceptable.**
- ~~**But S**~~**suicide is ~~also is~~ a preventable public health problem –** and unfortunately, our data show that the problem is getting worse.
- For this *Vital Signs* report, we first analyzed data from the National Vital Statistics System to look at trends in suicide rates for all 50 states and Washington, D.C.
- We then looked at data from CDC's National Violent Death Reporting System, covering 27 states in 2015, ~~and~~ and~~to~~ examined~~d~~ circumstances around suicides among people with and without known mental health ~~problems~~conditions. As a side note, in the coming year CDC will have data for 40 states, D.C. and Puerto Rico, and thanks to Congress for providing funding in the fiscal year 2018 omnibus, CDC is working to expand the system to all 50 states.
- **Suicide is often attributed solely to a mental health ~~problem~~condition. But according to NVDRS, fewer than half of the people who ~~who die by~~lost their life to suicide had~~ve~~ a known mental health ~~problem~~ condition – and in many of these cases, other factors wea~~re~~ involved.**

Comment [CA]: I suggest avoiding the dramatic words

Comment [ST(]: Do you think this is what she had in mind? It seems a bit off to make this point here like this.

Comment [zaf9]: It does seem to interrupt the flow a bit but if we want to keep it here, how about "As a side note, in the coming year we will have data for 40 states, D.C., and PR and fortunately, thanks to congress and the FY2018 omnibus bill, CDC will be plans to expand NVDRS to all 50 states.

- In fact, our research found that people who died by suicide and *did not* have a diagnosed mental health ~~problem~~ condition were somewhat more likely than those *with* a mental health ~~problem~~ condition to struggle with **relationship problems or loss, life stressors** and **recent or impending crises**. However, and **importantly**, these circumstances were common to both groups.
- **Suicide IS preventable.** ~~For example~~
- That's why it's so important to know the full range of factors that contribute to suicide risk including relationship problems, substance use, physical and mental health ~~problems~~conditions, job issues, financial trouble, and criminal and/or legal problems.
- With t~~T~~his information in mind, states and communities can ~~be used to~~ develop a comprehensive approach to suicide prevention. For example, The United States Air Force Suicide Prevention Program, inclusive of~~ding~~ 11 policy and education initiatives geared broadly towards increasing social support, social skills, and help-seeking, shifted the culture of the Air Force away from viewing suicide ~~and mental illness solely~~ as ~~medical~~an individual-oriented mental health ~~problem~~conditions~~s~~ ~~and instead as~~to a larger service-wide problem~~s~~ impacting the whole community. The program was associated with a 33% relative risk reduction in suicide and reductions in other related problems.~~.~~

Comment [ST(]: I feel like some transition is needed before introducing this. I move it down after a point about a comprehensive approach. What do you think of this?

Comment [zaf9]: Agree, good idea!

- Increased awareness of the range of circumstances contributing to suicide risk, and ~~what action is~~the needed to address them, can help the nation reach its goal of reducing the annual suicide rate 20 percent by 2025.
- Today's report suggests we have a lot of important work to do to reach this goal. Nearly **all states had increasing suicide rates between 1999 and 2016, and 25 states experienced rate increases of more than 30 percent.**
- So how do we work together to reverse these numbers and help save lives?
- Close coordination of activities between public health agencies and other sectors of society is critical for preventing suicide. Necessary partners include such sectors as health and mental healthcare providers; social services; ~~law enforcement~~first responders; educators; faith communities; ~~businesses~~employers; and the media.
- States and communities **can and should take action now** based on the best available evidence.
- To help prioritize prevention efforts, we've developed *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* It features the best available evidence for states and communities to guide their prevention priorities. The link to the technical package is on our *Vital Signs* website.

- **Preventing suicide involves everyone. Parents, employers, teachers, coaches, religious leaders – everyone in the community** can help prevent suicide risk, learn the warning signs of suicide, and how best to respond and get help.
- Now I'm going to turn it over to Dr. Adams for more discussion about suicide.

Dr. Adams:

- Thank you, Rear Admiral Anne Schuchat. As the nation's doctor, I am grateful for CDC's important work on this public health problem~~crisis~~.

- As Dr. Schuchat noted, suicide is a ~~devastating~~ serious national problem. It's simply not acceptable that we are now losing nearly 45,000 lives a year to suicide in this country, ~~many of whom are~~including many military members and~~or~~ veterans.
- On the Federal level, government agencies are tracking the problem of suicide to understand trends and to identify groups at greatest risk. We are developing, implementing, and evaluating what works to prevent suicide in communities. And we are working with public and private partners to advance the National Strategy for Suicide Prevention.

- The good news is that there are many opportunities for prevention. This *Vital Signs* report reminds us that health care systems and providers have important roles to play in preventing the risk of suicide. Some specific things primary, emergency, and behavioral healthcare providers can do:
    - First, you can help make sure there are ~~systems~~ policies and practices in place to screen, assess, and support people at risk, per clinical guidelines. And healthcare systems ~~you~~ can train their staff ~~in suicide care,~~ in these practices, and protocols, including safety planning.
    - Second, you can talk with people who are at risk – and their families – about how to safely store lethal means such as medications and firearms.
    - Finally, it is important to integrate and coordinate physical and behavioral~~/mental~~ health care in ways that keep patients safe and engaged in care so nobody falls through the cracks.
- Today's report shows that there are many factors that contribute to suicide risk. Everyone has a responsibility to help stop this ~~alarming~~ concerning trend.
- **Thank you, I'll turn it back to Dr. Schuchat now.**

Dr. Schuchat:

- **Thank you for your comments, Dr. Adams.**

Comment [ST(]: Deb, "suicide care" is unclear. We could just drop this and leave the rest or is there something else you would suggest adding here?

Comment [zaf9]: That's fine.

- The bottom line is that many factors contribute to suicide, beyond mental health ~~problem~~conditions alone. ~~It's a lot more than just a mental health problem for an individual.~~ So it will take a coordinated and comprehensive response to ~~make sure we~~ prevent ~~as many of these~~further tragic and unnecessary deaths ~~as we can~~.

  Everyone has a role to play in these efforts and hope and healing is possible.

- Thank you. I'll turn it back to our moderator now.

Moderator: Thank you. (Operator's name), I believe we are ready for questions, please.

[Q&A]

Media Q&A –AFTER FINAL QUESTION- (Moderator): Thank you Drs. Schuchat, Adams and Stone for joining us today, as well as reporters. Further information is available on this topic through our Vital Signs website, www.cdc.gov/vitalsigns. For follow-up questions, call the press office at 404-639-3286 or send an email to media@cdc.gov.

Thank you for joining us; this concludes our call.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 14 May 2018 16:52:42 +0000
To: Black, Erin (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief
Attachments: TELEBRIEF SCRIPT_V4_pgm_LS_5.7.18_1.40pm_TS_LS_SO.5.11.18.EB+ac+EB ds +EB ds 5.14.2018.docx

With attachment!
Hi Erin,
I noted a couple of typos due to tracked changes, a couple of places where problem wasn't replaced with condition and a few other minor things that are corrected.
Thanks!
Deb

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 12:37 PM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief
Attached is the current version of the script. Thank you Deb, Tom and Alex for your feedback. I am waiting to receive revisions from the SG's office on Dr. Adam's part and then will send back to the VS office. Please let me know if anyone has any additional feedback.

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 10:16 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: Re: Vital Signs FS and press release with modifications after the Pre-Brief
Greetings:
I reviewed the transcript, it looks good.
Alex C
Sent from my BlackBerry 10 smartphone.
From: Stone, Deborah (CDC/ONDIEH/NCIPC)

Sent: Sunday, May 13, 2018 19:33
To: Simon, Thomas (CDC/ONDIEH/NCIPC); Black, Erin (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC); Kegler, Scott R. (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Yuan, Keming (CDC/ONDIEH/NCIPC); Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Ballman, Marie R. (CDC/ONDIEH/NCIPC); Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

Thanks, Tom. This looks great. I've gone through and made some additional final edits. Tom and Alex, you may want to take one more look—sorry!
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Sunday, May 13, 2018 4:49 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

Hi Erin,
Thank you for moving this forward. I suggested a few edits in the version attached. There are some additional points to make in the terms box at the top that I pulled from the definitions document. Deb, I added a note for you. Also, are there any other key points that you want to be sure are made?
Erin, in the summary you provided about next steps you indicated that there was a request to put the % who disclosed suicidal thoughts in the script. Was that really to go in the script? It seems more appropriate for the Q & A.
The answer would be that the % of suicide decedents who disclosed suicide intent was slightly higher among those with mental health problems (24.5%) compared to those without known mental health problems (22.5%).
-Tom

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Saturday, May 12, 2018 12:01 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

Thanks Alex. I made your suggested edits in the attached. I also spoke to Tom and we decided to add the terminology guidance box and Air Force example. I did not add mention of the HP2020 goal, the % of people who told someone they were contemplating suicide or mention CDR Cunningham (since it hasn't

been reported as a suicide I don' think we should proactively discuss during a suicide VS release) rather add a TP to the Q&As incase a question is asked. Please let me know what you all think.

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 6:15 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: Re: Vital Signs FS and press release with modifications after the Pre-Brief

Greetings:
I have attached my comments. Pretty minor just some word choices.
Alex C
Sent from my BlackBerry 10 smartphone.

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 15:18
To: Simon, Thomas (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC); Kegler, Scott R. (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Yuan, Keming (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC); Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Ballman, Marie R. (CDC/ONDIEH/NCIPC); Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

All – wanted to get your thoughts on the script for Dr. S.
In working through the document, I made these updates:

- Updated the headlines based on comments today.
- Added a reference to thank congress for funding to expand NVDRS.
- Removed the reference to 'suicide care'.
- Added reference to age-specific rates overtime (but not the other sited work mentioned)
- Added percent of those that died by suicide who were military/vets (It seems weird to specifically call this out in the script but per Anne's request, let me know your thoughts).

Let me know your thoughts about the following that were discussed in the pre-brief– I think these are more appropriate in the Q&As than the script:

- Terminology guidance box – Added to the script
- HP2020 goal
- Air force example – Added to the script
- % of people who told someone they were contemplating suicide
- Mention of CDR Cunningham (I don't think it is confirmed he died by suicide, rather drowning)

Current version of the script is attached, let me know what you think. I hope to send to Leslie to take a quick look before sending back to the VS office COB Monday. Still waiting for edits from the SG's office on his piece – I sent them a reminder.
E

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 10, 2018 6:00 PM
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC)

<zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: Vital Signs FS and press release with modifications after the Pre-Brief

Hi VS team,

We really appreciated all the helpful feedback provided during the pre-brief with Dr. Schuchat. We also appreciate the guidance you provided before and after. The ideas that the graphics team provided for page 3 during the call yesterday seem like they will be helpful. We look forward to seeing the new version.

We are attaching a copy of the fact sheet pdf with embedded stickies to describe specific edits. These reflect the changes we discussed during and after the pre-brief. I'm also attaching a Word document that describes the changes that we discussed for page 3 during the call yesterday. We are providing shortened text for the figure that was at the top of page 3. I understand that this will be formatted using the new layout but we edited the text in the old format so you can see how it relates. Please use this new text. This document also provides the 5 steps to go on the bottom right of page 3 and some other specific edits to the title and warning signs text.

We are also attaching the press release with a few edits. We were reflecting on Dr. Schuchat's concern about small states and whether the increase could be based on a small number of suicides. Scott looked into this for us and we are comfortable that these are meaningful increases. He prepared a helpful Q & A about this (attached). Given this, we think it is ok to keep the text in the press release about the ranges across states. I wanted to mention this to you though in case you want to consult with Dr. Schuchat about this given the questions she raised.

Finally, regarding the request to reflect how the increases in suicide rates have varied across age group, we are proposing the addition of the following highlighted text to the introductory paragraph. Can you please check to see if this is consistent with what Dr. Schuchat would like?

BACKGROUND AND PURPOSE

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (1). Between 1999 and 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (2,3). Suicide rates have increased among all age groups younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14 (3). Suicide is the 10th leading cause of death and is one of just three leading causes that are increasing (1,4). Additionally, rates of emergency department visits for nonfatal self-harm, a key risk factor for suicide, increased 42% between 2001 and 2015 (1). Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs (1).

Thank you!

Tom, Deb, and our VS team

Review Tracker

- NCIPC OC Leslie Dorigo: 4/25/18
- DVP ADS Tom Simon: 4/24/18
- DVP Policy Malia Richmond-Crum: 4/23/18
- DVP SME Deb Stone: 4/19/18, 4/24/18, 5/13
- DVP HCET Marie Ballman: 4/17/2018
- LS-OADC: 5/1/2018
- KSG-OADC: 5/4/2018

Suicide Terminology	
Don't Do This	**Do This Instead**
Don't use sensationalistic headlines (e.g., Kurt Cobain used shotgun to commit suicide)	Do inform without sensationalizing (e.g. Curt Cobain dead at 27)
Don't describe suicide as an epidemic, skyrocketing, etc.	Do use the most recent CDC data and non-sensational words (rise, higher, etc.)
Don't describe suicide as inexplicable or "without warning"	Do include the 'warning signs' and 'what to do' info in articles
Don't refer to suicides or as 'successful' or 'completed'	Describe as suicide, person died by suicide, or life lost to suicide
Don't refer to suicide attempts as 'unsuccessful,' 'failed attempt' or 'nonfatal suicide'	Describe as 'suicide attempt' or 'suicidal self-directed violence'

Vital Signs Rising Suicide Rates Across U.S.

June 7, 2018

Desired Headlines

- Nearly 45,000 lives lost to suicide~~s occurred~~ in 2016, but suicide is preventable.
- Suicide rates ~~going~~ up in almost all states, but suicide is preventable.
- Suicide rates ~~s increased~~ went up more than 30% in half of U.S. states between 1999 and 2016.
- Many factors contribute to suicide, beyond mental health problems alone ~~contribute to suicide~~.

Moderator: Thank you (OPERATOR NAME). And thank you all for joining us today for the release of a new CDC Vital Signs report, ~~this one~~ on ~~Circumstances and~~ Trends in State Suicide Rates and contributing circumstances to suicide. We are joined by Dr. Anne Schuchat, CDC's Principal Deputy Director and the Surgeon General Dr. Jerome Adams. Dr. Deb Stone, ~~one of the~~lead author~~s~~ of the study, is also available to help

withanswer questions. Following remarks, we will respond to questions. I'd like to turn the call over now to Dr. Anne Schuchat.

Dr. Schuchat:

- Good afternoon and thank you for joining us today.
- CDC works 24/7 to protect Americans against health threats. Each month in CDC's *Vital Signs* report, **we focus on one of these threats – and what can be done about it**.
- Today's report contains **alarming new information about state suicide trends, and the range of factors that contribute to itsuicide.**
- In 2016 alone, **45,000 people in the U.S. lost their lives to suicide.**
- What we found is that **suicide rates have increased in nearly every state** across the nation – and suicide is it's one of just three leading causes of death that are on the rise.
- **Suicide rRates have increased among all age groups** younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14.

- ~~These are devastating findings are unacceptable.~~ ~~We know that every~~Ssuicide greatly ~~is a tragedy for those individuals, their~~impacts families, friends, ~~and~~ colleagues, and entire communities. **These findings are unacceptable.**
- **~~But~~ Ssuicide is ~~also is~~ a preventable public health problem –** and unfortunately, our data show that the problem is getting worse.
- For this *Vital Signs* report, we first analyzed data from the National Vital Statistics System to look at trends in suicide rates for all 50 states and Washington, D.C.
- We then looked at data from CDC's National Violent Death Reporting System, covering 27 states in 2015, ~~and~~ and~~to~~ examined~~d~~ circumstances around suicides among people with and without known mental health ~~problems~~conditions. As a side note, in the coming year CDC will have data for 40 states, D.C. and Puerto Rico, and thanks to Congress for providing funding in the fiscal year 2018 omnibus, CDC is working to expand the system to all 50 states.
- **Suicide is often attributed solely to a mental health ~~problem~~condition. But according to NVDRS, fewer than half of the people who ~~who die by~~lost their life to suicide had~~ve~~ a known mental health ~~problem~~ condition – and in many of these cases, other factors weare involved.**
- In fact, our research found that people who died by suicide and *did not* have a diagnosed mental health ~~problem~~ condition were somewhat more likely than

Comment [CA]: I suggest avoiding the dramatic words

Comment [ST(]: Do you think this is what she had in mind? It seems a bit off to make this point here like this.

Comment [zaf9]: It does seem to interrupt the flow a bit but if we want to keep it here, how about "As a side note, in the coming year we will have data for 40 states, D.C., and PR and fortunately, thanks to congress and the FY2018 omnibus bill, CDC will be plans to expand NVDRS to all 50 states.

those *with* a mental health ~~problem~~ condition to struggle with **relationship problems or loss, life stressors** and **recent or impending crises**. However, and **importantly**, these circumstances were common to both groups.

- **Suicide IS preventable.** ~~For~~ ~~example~~
- That's why it's so important to know the full range of factors that contribute to suicide risk including relationship problems, substance use, physical and mental health ~~problems~~conditions, job issues, financial trouble, and criminal and/or legal problems.
- With t~~T~~his information in mind, states and communities can ~~be used to~~ develop a comprehensive approach to suicide prevention. For example, The United States Air Force Suicide Prevention Program, inclusive of~~ding~~ 11 policy and education initiatives geared broadly towards increasing social support, social skills, and help-seeking, shifted the culture of the Air Force away from viewing suicide ~~and mental illness solely~~ as ~~medical~~an individual-oriented mental health ~~problem~~conditions~~s~~ ~~and instead as~~to a larger service-wide problem~~s~~ impacting the whole community. The program was associated with a 33% relative risk reduction in suicide and reductions in other related problems.~~.~~

Comment [ST(]: I feel like some transition is needed before introducing this. I move it down after a point about a comprehensive approach. What do you think of this?

Comment [zaf9]: Agree, good idea!

- Increased awareness of the range of circumstances contributing to suicide risk, and ~~what action is~~the needed to address them, can help the nation reach its goal of reducing the annual suicide rate 20 percent by 2025.
- Today's report suggests we have a lot of important work to do to reach this goal. Nearly **all states had increasing suicide rates between 1999 and 2016, and 25 states experienced rate increases of more than 30 percent.**
- So how do we work together to reverse these numbers and help save lives?
- Close coordination of activities between public health agencies and other sectors of society is critical for preventing suicide. Necessary partners include such sectors as health and mental healthcare providers; social services; ~~law enforcement~~first responders; educators; faith communities; ~~businesses~~employers; and the media.
- States and communities **can and should take action now** based on the best available evidence.
- To help prioritize prevention efforts, we've developed *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* It features the best available evidence for states and communities to guide their prevention priorities. The link to the technical package is on our *Vital Signs* website.

- **Preventing suicide involves everyone. Parents, employers, teachers, coaches, religious leaders – everyone in the community** can help prevent suicide risk, learn the warning signs of suicide, and how best to respond and get help.
- Now I'm going to turn it over to Dr. Adams for more discussion about suicide.

Dr. Adams:

- Thank you, Rear Admiral Anne Schuchat. As the nation's doctor, I am grateful for CDC's important work on this public health problem~~crisis~~.

- As Dr. Schuchat noted, suicide is a ~~devastating~~ serious national problem. It's simply not acceptable that we are now losing nearly 45,000 lives a year to suicide in this country, ~~many of whom are~~including many military members and~~or~~ veterans.
- On the Federal level, government agencies are tracking the problem of suicide to understand trends and to identify groups at greatest risk. We are developing, implementing, and evaluating what works to prevent suicide in communities. And we are working with public and private partners to advance the National Strategy for Suicide Prevention.

- The good news is that there are many opportunities for prevention. This *Vital Signs* report reminds us that health care systems and providers have important roles to play in preventing the risk of suicide. Some specific things primary, emergency, and behavioral healthcare providers can do:
    - First, you can help make sure there are ~~systems~~ policies and practices in place to screen, assess, and support people at risk, per clinical guidelines. And healthcare systems ~~you~~ can train their staff ~~in suicide care,~~ in these practices, and protocols, including safety planning.
    - Second, you can talk with people who are at risk – and their families – about how to safely store lethal means such as medications and firearms.
    - Finally, it is important to integrate and coordinate physical and behavioral~~/mental~~ health care in ways that keep patients safe and engaged in care so nobody falls through the cracks.
- Today's report shows that there are many factors that contribute to suicide risk. Everyone has a responsibility to help stop this ~~alarming~~ concerning trend.
- **Thank you, I'll turn it back to Dr. Schuchat now.**

Dr. Schuchat:

- **Thank you for your comments, Dr. Adams.**

Comment [ST(]: Deb, "suicide care" is unclear. We could just drop this and leave the rest or is there something else you would suggest adding here?

Comment [zaf9]: That's fine.

- The bottom line is that many factors contribute to suicide, beyond mental health ~~problem~~conditions alone. ~~It's a lot more than just a mental health problem for an individual.~~ So it will take a coordinated and comprehensive response to ~~make sure we~~ prevent ~~as many of these~~further tragic and unnecessary deaths ~~as we can~~.

  Everyone has a role to play in these efforts and hope and healing is possible.

- Thank you. I'll turn it back to our moderator now.

Moderator: Thank you. (Operator's name), I believe we are ready for questions, please.

[Q&A]

Media Q&A –AFTER FINAL QUESTION- (Moderator): Thank you Drs. Schuchat, Adams and Stone for joining us today, as well as reporters. Further information is available on this topic through our Vital Signs website, www.cdc.gov/vitalsigns. For follow-up questions, call the press office at 404-639-3286 or send an email to media@cdc.gov.

Thank you for joining us; this concludes our call.

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 14 May 2018 12:36:53 -0400
To: Crosby, Alexander (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief
Attachments: TELEBRIEF SCRIPT_V4_pgm_LS_5.7.18_1.40pm_TS_LS_SO.5.11.18.EB+ac+EB ds +EB5.14.2018.docx

Attached is the current version of the script. Thank you Deb, Tom and Alex for your feedback. I am waiting to receive revisions from the SG's office on Dr. Adam's part and then will send back to the VS office. Please let me know if anyone has any additional feedback.

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 10:16 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: Re: Vital Signs FS and press release with modifications after the Pre-Brief

Greetings:
I reviewed the transcript, it looks good.
Alex C
Sent from my BlackBerry 10 smartphone.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Sunday, May 13, 2018 19:33
To: Simon, Thomas (CDC/ONDIEH/NCIPC); Black, Erin (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC); Kegler, Scott R. (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Yuan, Keming (CDC/ONDIEH/NCIPC); Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Ballman, Marie R. (CDC/ONDIEH/NCIPC); Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

Thanks, Tom. This looks great. I've gone through and made some additional final edits. Tom and Alex, you may want to take one more look—sorry!
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Sunday, May 13, 2018 4:49 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>

Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

Hi Erin,

Thank you for moving this forward. I suggested a few edits in the version attached. There are some additional points to make in the terms box at the top that I pulled from the definitions document. Deb, I added a note for you. Also, are there any other key points that you want to be sure are made?

Erin, in the summary you provided about next steps you indicated that there was a request to put the % who disclosed suicidal thoughts in the script. Was that really to go in the script? It seems more appropriate for the Q & A.

The answer would be that the % of suicide decedents who disclosed suicide intent was slightly higher among those with mental health problems (24.5%) compared to those without known mental health problems (22.5%).

-Tom

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Saturday, May 12, 2018 12:01 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

Thanks Alex. I made your suggested edits in the attached. I also spoke to Tom and we decided to add the terminology guidance box and Air Force example. I did not add mention of the HP2020 goal, the % of people who told someone they were contemplating suicide or mention CDR Cunningham (since it hasn't been reported as a suicide I don' think we should proactively discuss during a suicide VS release) rather add a TP to the Q&As incase a question is asked. Please let me know what you all think.

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 6:15 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: Re: Vital Signs FS and press release with modifications after the Pre-Brief

Greetings:

I have attached my comments. Pretty minor just some word choices.

Alex C

Sent from my BlackBerry 10 smartphone.

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 15:18

To: Simon, Thomas (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC); Kegler, Scott R. (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Yuan, Keming (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC); Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Ballman, Marie R. (CDC/ONDIEH/NCIPC); Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

All – wanted to get your thoughts on the script for Dr. S.
In working through the document, I made these updates:

- Updated the headlines based on comments today.
- Added a reference to thank congress for funding to expand NVDRS.
- Removed the reference to 'suicide care'.
- Added reference to age-specific rates overtime (but not the other sited work mentioned)
- Added percent of those that died by suicide who were military/vets (It seems weird to specifically call this out in the script but per Anne's request, let me know your thoughts).

Let me know your thoughts about the following that were discussed in the pre-brief– I think these are more appropriate in the Q&As than the script:

- Terminology guidance box – Added to the script
- HP2020 goal
- Air force example – Added to the script
- % of people who told someone they were contemplating suicide
- Mention of CDR Cunningham (I don't think it is confirmed he died by suicide, rather drowning)

Current version of the script is attached, let me know what you think. I hope to send to Leslie to take a quick look before sending back to the VS office COB Monday. Still waiting for edits from the SG's office on his piece – I sent them a reminder.
E

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 10, 2018 6:00 PM
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: Vital Signs FS and press release with modifications after the Pre-Brief

Hi VS team,
We really appreciated all the helpful feedback provided during the pre-brief with Dr. Schuchat. We also appreciate the guidance you provided before and after. The ideas that the graphics team provided for page 3 during the call yesterday seem like they will be helpful. We look forward to seeing the new version.
We are attaching a copy of the fact sheet pdf with embedded stickies to describe specific edits. These reflect the changes we discussed during and after the pre-brief. I'm also attaching a Word document that describes the changes that we discussed for page 3 during the call yesterday. We are providing shortened text for the figure that was at the top of page 3. I understand that this will be formatted using

the new layout but we edited the text in the old format so you can see how it relates. Please use this new text. This document also provides the 5 steps to go on the bottom right of page 3 and some other specific edits to the title and warning signs text.

We are also attaching the press release with a few edits. We were reflecting on Dr. Schuchat's concern about small states and whether the increase could be based on a small number of suicides. Scott looked into this for us and we are comfortable that these are meaningful increases. He prepared a helpful Q & A about this (attached). Given this, we think it is ok to keep the text in the press release about the ranges across states. I wanted to mention this to you though in case you want to consult with Dr. Schuchat about this given the questions she raised.

Finally, regarding the request to reflect how the increases in suicide rates have varied across age group, we are proposing the addition of the following highlighted text to the introductory paragraph. Can you please check to see if this is consistent with what Dr. Schuchat would like?

BACKGROUND AND PURPOSE

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (1). Between 1999 and 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (2,3). Suicide rates have increased among all age groups younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14 (3). Suicide is the 10th leading cause of death and is one of just three leading causes that are increasing (1,4). Additionally, rates of emergency department visits for nonfatal self-harm, a key risk factor for suicide, increased 42% between 2001 and 2015 (1). Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs (1).

Thank you!

Tom, Deb, and our VS team

Review Tracker

- NCIPC OC Leslie Dorigo: 4/25/18
- DVP ADS Tom Simon: 4/24/18
- DVP Policy Malia Richmond-Crum: 4/23/18
- DVP SME Deb Stone: 4/19/18, 4/24/18, 5/13
- DVP HCET Marie Ballman: 4/17/2018
- LS-OADC: 5/1/2018
- KSG-OADC: 5/4/2018

Suicide Terminology	
Don't Do This	**Do This Instead**
Don't use sensationalistic headlines (e.g., Kurt Cobain used shotgun to commit suicide)	Do inform without sensationalizing (e.g. Curt Cobain dead at 27)
Don't describe suicide as an epidemic, skyrocketing, etc.	Do use the most recent CDC data and non-sensational words (rise, higher, etc.)
Don't describe suicide as inexplicable or "without warning"	Do include the 'warning signs' and 'what to do' info in articles
Don't refer to suicides or as 'successful' or 'completed'	Describe as suicide, person died by suicide, or life lost to suicide
Don't refer to suicide attempts as 'unsuccessful,' 'failed attempt' or 'nonfatal suicide'	Describe as 'suicide attempt' or 'suicidal self-directed violence'

Vital Signs Rising Suicide Rates Across U.S.

June 7, 2018

Desired Headlines

- Nearly 45,000 lives lost to suicide~~s occurred~~ in 2016, but suicide is preventable.
- Suicide rates ~~going~~ up in almost all states, but suicide is preventable.
- Suicide rates ~~s increased~~ went up more than 30% in half of U.S. states between 1999 and 2016.
- Many factors contribute to suicide, beyond mental health problems alone ~~contribute to suicide~~.

Moderator: Thank you (OPERATOR NAME). And thank you all for joining us today for the release of a new CDC Vital Signs report, ~~this one~~ on ~~Circumstances and~~ Trends in State Suicide Rates and contributing circumstances to suicide. We are joined by Dr. Anne Schuchat, CDC's Principal Deputy Director and the Surgeon General Dr. Jerome Adams. Dr. Deb Stone, ~~one of the~~lead author~~s~~ of the study, is also available to help

withanswer questions. Following remarks, we will respond to questions. I'd like to turn the call over now to Dr. Anne Schuchat.

Dr. Schuchat:

- Good afternoon and thank you for joining us today.
- CDC works 24/7 to protect Americans against health threats. Each month in CDC's *Vital Signs* report, **we focus on one of these threats – and what can be done about it**.
- Today's report contains **alarming new information about state suicide trends, and the range of factors that contribute to itsuicide.**
- In 2016 alone, **45,000 people in the U.S. lost their lives to suicide.**
- What we found is that **suicide rates have increased in nearly every state** across the nation – and suicide is it's one of just three leading causes of death that are on the rise.
- **Suicide rRates have increased among all age groups** younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14.

- ~~These are devastating findings are unacceptable.~~ ~~We know that every~~Ssuicide greatly ~~is a tragedy for those individuals, their~~impacts families, friends, ~~and~~ colleagues, and entire communities. **These findings are unacceptable.**
- **~~But~~ Ssuicide is ~~also is~~ a preventable public health problem –** and unfortunately, our data show that problem is getting worse.
- For this *Vital Signs* report, we first analyzed data from the National Vital Statistics System to look at trends in suicide rates for all 50 states and Washington, D.C.
- We then looked at data from CDC's National Violent Death Reporting System, covering 27 states in 2015, ~~and~~ and~~to~~ examined~~d~~ circumstances around suicides among people with and without known mental health ~~problems~~conditions. As a side note, in the coming year CDC will have data for 40 states, D.C. and Puerto Rico, and thanks to Congress for providing funding in the fiscal year 2018 omnibus, CDC is working to expand the system to all 50 states.
- **Suicide is often attributed solely to a mental health problem. But according to NVDRS, fewer than half of the people who ~~who die by~~lost their life to suicide hadve a known mental health problem – and in many of these cases, other factors weare involved.**
- In fact, our research found that people who died by suicide and *did not* have a diagnosed mental health ~~problem~~ condition were somewhat more likely than

Comment [CA]: I suggest avoiding the dramatic words

Comment [ST(]: Do you think this is what she had in mind? It seems a bit off to make this point here like this.

Comment [zaf9]: It does seem to interrupt the flow a bit but if we want to keep it here, how about "As a side note, in the coming year we will have data for 40 states, D.C., and PR and fortunately, thanks to congress and the FY2018 omnibus bill, CDC will be plans to expand NVDRS to all 50 states.

those *with* a mental health ~~problem~~ condition to struggle with **relationship problems or loss, life stressors** and **recent or impending crises**. However, and **importantly**, these circumstances were common to both groups.

- **Suicide IS preventable.** ~~For example~~
- That's why it's so important to know the full range of factors that contribute to suicide risk including relationship problems, substance use, physical and mental health ~~problems~~conditions, job issues, financial trouble, and criminal and/or legal problems.
- With t~~T~~his information in mind, states and communities can ~~be used to~~ develop a comprehensive approach to suicide prevention. For example, The United States Air Force Suicide Prevention Program, which inclusive of~~ding~~ 11 policy and education initiatives geared broadly towards increasing social support, social skills, and help-seeking, shifted the culture of the Air Force away from viewing suicide ~~and mental illness solely~~ as ~~medical~~an individual-oriented mental health ~~problem~~conditions ~~and instead as~~to a larger service-wide problem~~s~~ impacting the whole community. The program was associated with a 33% relative risk reduction in suicide and reductions in other related problems.~~.~~

Comment [ST(]: I feel like some transition is needed before introducing this. I move it down after a point about a comprehensive approach. What do you think of this?

Comment [zaf9]: Agree, good idea!

- Increased awareness of the range of circumstances contributing to suicide risk, and what action is needed to address them, can help the nation reach its goal of reducing the annual suicide rate 20 percent by 2025.
- Today's report suggests we have a lot of important work to do to reach this goal. Nearly **all states had increasing suicide rates between 1999 and 2016, and 25 states experienced rate increases of more than 30 percent.**
- So how do we work together to reverse these numbers and help save lives?
- Close coordination of activities between public health agencies and other sectors of society influencing suicide risk is critical for preventing suicide. Necessary partners include such sectors as health and mental healthcare providers; social services; ~~law enforcement~~first responders; educators; faith communities; businesses; and the media.
- States and communities **can and should take action now** based on the best available evidence.
- To help prioritize prevention efforts, we've developed *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* It features the best available evidence for states and communities to guide their prevention priorities. The link to the technical package is on our *Vital Signs* website.

- **Preventing suicide involves everyone. Parents, employers, teachers, coaches, religious leaders – everyone in the community** can help prevent suicide risk, learn the warning signs of suicide, and how best to respond and get help.
- Now I'm going to turn it over to Dr. Adams for more discussion about suicide.

Dr. Adams:

- Thank you, Rear Admiral Anne Schuchat. As the nation's doctor, I am grateful for CDC's important work on this public health problem~~crisis~~.

- As Dr. Schuchat noted, suicide is a ~~devastating~~ serious national problem. It's simply not acceptable that we are now losing nearly 45,000 lives a year to suicide in this country, ~~many of whom are~~including military members and~~or~~ veterans.
- On the Federal level, government agencies are tracking the problem of suicide to understand trends and to identify groups at greatest risk. We are developing, implementing, and evaluating what works to prevent suicide in communities. And we are working with public and private partners to advance the National Strategy for Suicide Prevention.
- The good news is that there are many opportunities for prevention. This *Vital Signs* report reminds us that health care systems and providers have important

roles to play in preventing the risk of suicide. Some specific things primary, emergency, and behavioral healthcare providers can do:

- First, you can help make sure there are ~~systems~~ policies and practices in place to screen, assess, and support people at risk, per clinical guidelines. And healthcare systems ~~you~~ can train their staff ~~in suicide care,~~ in these practices, and protocols, including safety planning.
- Second, you can talk with people who are at risk – and their families – about how to safely store lethal means such as medications and firearms.
- Finally, it is important to integrate and coordinate physical and behavioral~~/mental~~ health care in ways that keep patients safe and engaged in care so people don't fall through the cracks.

- Today's report shows that there are many factors that contribute to suicide risk. Everyone has a responsibility to help stop this ~~alarming~~ concerning trend.
- **Thank you, I'll turn it back to Dr. Schuchat now.**

Dr. Schuchat:

- **Thank you for your comments, Dr. Adams.**
- The bottom line is that many factors contribute to suicide, beyond mental health ~~problem~~conditions alone. ~~It's a lot more than just a mental health problem for an~~

Comment [ST(]: Deb, "suicide care" is unclear. We could just drop this and leave the rest or is there something else you would suggest adding here?

Comment [zaf9]: That's fine.

~~individual.~~ So it will take a coordinated and comprehensive response to ~~make sure we~~ prevent ~~as many of these~~further tragic and unnecessary deaths ~~as we can~~.

Everyone has a role to play in these efforts and hope and healing is possible.

- Thank you. I'll turn it back to our moderator now.

Moderator: Thank you. (Operator's name), I believe we are ready for questions, please.

[Q&A]

Media Q&A –AFTER FINAL QUESTION- (Moderator): Thank you Drs. Schuchat, Adams and Stone for joining us today, as well as reporters. Further information is available on this topic through our Vital Signs website, www.cdc.gov/vitalsigns. For follow-up questions, call the press office at 404-639-3286 or send an email to media@cdc.gov.

Thank you for joining us; this concludes our call.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 14 May 2018 14:57:43 +0000
To: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

Thanks, Alex!

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Monday, May 14, 2018 10:16 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: Re: Vital Signs FS and press release with modifications after the Pre-Brief

Greetings:
I reviewed the transcript, it looks good.
Alex C
Sent from my BlackBerry 10 smartphone.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Sunday, May 13, 2018 19:33
To: Simon, Thomas (CDC/ONDIEH/NCIPC); Black, Erin (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC); Kegler, Scott R. (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Yuan, Keming (CDC/ONDIEH/NCIPC); Holland, Kristin (CDC/ONDIEH/NCIPC)
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Tom, Deb, and our VS team

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Sent: 13 May 2018 22:31:07 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
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Attachments: TELEBRIEF SCRIPT_V4_pgm_LS_5.7.18_1.40pm_TS_LS_SO.5.11.18.EB+ac+EB ds.docx

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To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Cc: Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Subject: Re: Vital Signs FS and press release with modifications after the Pre-Brief

Greetings:
I have attached my comments. Pretty minor just some word choices.
Alex C
Sent from my BlackBerry 10 smartphone.

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 15:18
To: Simon, Thomas (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC); Kegler, Scott R. (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Yuan, Keming (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC); Holland, Kristin (CDC/ONDIEH/NCIPC)
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Sent: Thursday, May 10, 2018 6:00 PM
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BACKGROUND AND PURPOSE

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (1). Between 1999 and 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (2,3). Suicide rates have increased among all age groups younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14 (3). Suicide is the 10th leading cause of death and is one of just three leading causes that are increasing (1,4). Additionally, rates of emergency department visits for nonfatal self-harm, a key risk factor for suicide, increased 42% between 2001 and 2015 (1). Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs (1).

Thank you!

Tom, Deb, and our VS team

Telebrief Script_V3_pgm_LS_NMB_5072018_952a

Review Tracker

- NCIPC OC Leslie Dorigo: 4/25/18
- DVP ADS Tom Simon: 4/24/18
- DVP Policy Malia Richmond-Crum: 4/23/18
- DVP SME Deb Stone: 4/19/18, 4/24/18, 5/13
- DVP HCET Marie Ballman: 4/17/2018
- LS-OADC: 5/1/2018
- KSG-OADC: 5/4/2018

Suicide Terminology~~Reporting Guidelines~~	
Don't Do This	**Do This Instead**
Don't use sensationalistic headlines (e.g., Kurt Cobain used shotgun to commit suicide)	Do inform without sensationalizing (e.g. Curt Cobain dead at 27)
~~Don't include photos/videos of the location, method, grieving family/friends, or memorials/funerals~~	~~Do use a school/work or family photo and include the lifeline number~~
Don't describe suicide as an epidemic, skyrocketing, etc.	Do use the most recent CDC data and non-sensational wordks (rise, higher, etc.)
Don't describe suicide as inexplicable or~~use~~ "without warning"	Do include the 'warning signs' and 'what to do' info in articles
~~Don't use "left a suicide note saying..."~~	~~Do indicate a note was found and is being reviewed~~
~~Don't investigate and report on suicide like reporting on crimes~~	~~Do report on suicide as a public health issue~~
~~Don't quote/interview first responders about the causes of suicide~~	~~Do seek advice from suicide prevention experts~~
Don't refer to suicide or suicide attempts as 'successful, or ' unsuccessful,'	Describe as suicide, person died by suicide, or life lost to suicide and refer to suicide attempts as such (not as successful or unsuccessful)

omment [ST(]: I don't think you need include the points that are only levant for media reporting here. This is eant to give Dr. S and Adams a primer terms they should avoid. I deleted the ws I thought were not necessary. That id it would be good to include points for e following from the definitions doc: her terms not to use include the llowing:

Completed suicide - Alternate rm: suicide
Failed attempt - Alternate terms: suicide tempt or suicidal self-directed violence.
Nonfatal suicide –Alternate term: icide attempt
Successful suicide – Alternate term: icide.

Vital Signs Rising Suicide Rates Across [illegible]

June 7, 2018

Desired Headlines

- Nearly 45,000 lives lost to suicide~~s occurred~~ in 2016, but suicide is preventable.
- Suicide rates ~~going~~ up in almost all states, but suicide is preventable.
- Suicide rates ~~s increased~~ went up more than 30% in half of U.S. states between 1999 and 2016.
- Many factors contribute to suicide, beyond mental health problems alone ~~contribute to suicide~~.

Moderator: Thank you (OPERATOR NAME). And thank you all for joining us today for the release of a new CDC Vital Signs report~~, this one~~ on ~~Circumstances and~~ Trends in State Suicide Rates and contributing circumstances to suicide. We are joined by Dr. Anne Schuchat, CDC's Principal Deputy Director and the Surgeon General Dr. Jerome

Adams. Dr. Deb Stone, ~~one of the~~lead author~~s~~ of the study, is also available to help w~~ith~~answer questions. Following remarks, we will respond to questions. I'd like to turn the call over now to Dr. Anne Schuchat.

Dr. Schuchat:

- Good afternoon and thank you for joining us today.
- CDC works 24/7 to protect Americans against health threats. Each month in CDC's *Vital Signs* report, **we focus on one of these threats – and what can be done about it**.
- Today's report contains **~~alarming~~ new information about state suicide trends, and the range of factors that contribute to ~~it~~suicide.**
- In 2016 alone, **45,000 people in the U.S. lost their lives to suicide.**
- W~~hat w~~e found ~~is~~ that **suicide rates have increased in nearly every state** across the nation – and suicide is ~~it's~~ one of just three leading causes of death that are on the rise.
- Suicide r**R**ates have **increased among all age groups** younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14.

- ~~In 2016 alone, **45,000 people in the U.S. lost their lives to suicide**.~~ 17.8% ~~of those who died by suicide were **currently serving or ever served in the military.**~~
-
- ~~**These are devastating findings are unacceptable.** We know that every~~ Ssuicide greatly ~~is a tragedy for those individuals, their~~impacts families, friends, ~~and~~ colleagues, and entire communities. **These findings are unacceptable.**
- ~~**But S**~~**suicide is ~~also is~~ a preventable public health problem –** and unfortunately, our data show that problem is getting worse.
- For this *Vital Signs* report, we first analyzed data from the National Vital Statistics System to look at trends in suicide rates for all 50 states and Washington, D.C.
- We then looked at data from CDC's National Violent Death Reporting System, covering 27 states in 2015, ~~and~~ and~~to~~ examined~~d~~ circumstances around suicides among people with and without known mental health problems. I'd like to take this opportunity to thank Congress for providing funding in the fiscal year 2018 omnibus to expand the system to all 50 states and the District of Columbia. CDC is actively working toward that goal.
-
- **Suicide is often attributed solely to a mental health problem. But according to NVDRS, fewer than half of the people who ~~who die by~~lost their life to suicide**

Comment [ST(]: I would take this out of script for Dr. S since it is not a primary finding.

Comment [BE(]: Please check this is accurate.

Comment [CA]: I suggest avoiding the dramatic words

Comment [ST(]: Do you think this is what she had in mind? It seems a bit off to make this point here like this.

Comment [zaf9]: It does seem to interrupt the flow a bit but if we want to keep it here, how about "As a side note, in the coming year we will have data for 40 states, D.C., and PR and fortunately, thanks to congress and the FY2018 omnibus bill, CDC will be plans to expand NVDRS to all 50 states.

Comment [zaf9]: I don't think we need this as it begs the question of why would cdc have to work so hard toward this if congress already provided funds. I think this is TMI.

hadve a known mental health problem – and in many of these cases, other factors weare involved.

- In fact, our research found that people who died by suicide and *did not* have a diagnosed mental health problem were somewhat more likely than those *with* a mental health problem to struggle with **relationship problems or loss, life stressors** and **recent or impending crises**. However, and **importantly**, these circumstances were common to both groups.
- **Suicide IS preventable.** ~~For example, The *United States Air Force Suicide Prevention Program*, including 11 policy and education initiatives, shifted the culture if the Air Force from viewing suicide and mental illness solely as medical problems and instead as larger service-wide problems impacting the whole community. The program was associated with a 33% relative risk reduction in suicide.~~
- That's why it's so important to know the full range of factors that contribute to suicide risk including relationship problems, substance use, physical and mental health problems, job issues, financial trouble, and criminal and/or legal problems.
- With t~~T~~his information in mind, states and communities can ~~be used to~~ develop a comprehensive approach to suicide prevention. For example, The United States Air Force Suicide Prevention Program, which inclusive of~~ding~~ 11 policy and education initiatives geared broadly towards increasing social support, social skills, and help-seeking, shifted the culture of the Air Force away from viewing suicide ~~and mental illness solely~~ as ~~medical~~an individual-oriented mental health

Comment [zaf9]: I think it's ok to sometimes use 'died by suicide' to get people familiar with this phrase.

Comment [ST(]: I feel like some transition is needed before introducing this. I move it down after a point about a comprehensive approach. What do you think of this?

Comment [zaf9]: Agree, good idea!

Comment [zaf9]: We need to be careful to not say mental health is a risk factor for suicide—it's problems with mental health that's the issue!

problems ~~and instead as~~to a larger service-wide problems impacting the whole community. The program was associated with a 33% relative risk reduction in suicide and reductions in other related problems.~~.~~

-
- Increased awareness of the range of circumstances contributing to suicide risk, and what action is needed to address them, can help the nation reach its goal of reducing the annual suicide rate 20 percent by 2025.
- Today's report suggests we have a lot of important work to do to reach this goal. Nearly **all states had increasing suicide rates between 1999 and 2016, and 25 states experienced rate increases of more than 30 percent.**
- So how do we work together to reverse these numbers and help save lives?

-
- Close coordination of activities between public health agencies and other sectors of society influencing suicide risk is critical for preventing suicide. Necessary partners include such sectors as health ~~care~~ and mental healthcare providers; social services; ~~law enforcement~~first responders; educators; faith communities; businesses; and the media.
- States and communities **can and should take action now** based on the best available evidence.
- To help prioritize prevention efforts, we've developed *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* It features the best available

evidence for states and communities to guide their prevention priorities. The link to the technical package is on our *Vital Signs* website.

- **Preventing suicide involves everyone. Parents, employers, teachers, coaches, religious leaders – everyone in the community** can help prevent suicide risk, learn the warning signs of suicide, and how best to respond and get help.
- Now I'm going to turn it over to Dr. Adams for more discussion about suicide.

Dr. Adams:

- Thank you, Rear Admiral Anne Schuchat. As the nation's doctor, I am grateful for CDC's important work on this public health problem~~crisis~~.

- As Dr. Schuchat noted, suicide is a ~~devastating~~ serious national problem. It's simply not acceptable that we are now losing nearly 45,000 lives a year to suicide in this country, ~~many of whom are~~including military members and~~or~~ veterans.
- On the Federal level, government agencies are tracking the problem of suicide to understand trends and to identify groups at greatest risk. We are developing, implementing, and evaluating what works to prevent suicide in communities. And we are working with public and private partners to advance the National Strategy for Suicide Prevention.

- The good news is that there are many opportunities for prevention. This *Vital Signs* report reminds us that health care systems and providers have important roles to play in preventing the risk of suicide. Some specific things primary, emergency, and behavioral healthcare providers can do:
    - First, you can help make sure there are ~~systems~~ policies and practices in place to screen, assess, and support people at risk, per clinical guidelines. And healthcare systems ~~you~~ can train their staff ~~in suicide care,~~ in these practices, and protocols, including safety planning.
    -
    - Second, you can talk with people who are at risk – and their families – about how to safely store lethal means such as medications and firearms.
    - Finally, it is important to integrate and coordinate physical and behavioral~~/mental~~ health care in ways that keep patients safe and engaged in care so people don't fall through the cracks.
- Today's report shows that there are many factors that contribute to suicide risk. Everyone has a responsibility to help stop this ~~alarming~~ concerning trend.
- **Thank you, I'll turn it back to Dr. Schuchat now.**

Dr. Schuchat:

Comment [ST(]: Deb, "suicide care" is unclear. We could just drop this and leave the rest or is there something else you would suggest adding here?

Comment [zaf9]: That's fine.

Comment [zaf9]: Behavioral includes mental health and substance abuse services

- **Thank you for your comments, Dr. Adams.**

- The bottom line is that many factors contribute to suicide, beyond mental health problems alone. ~~It's a lot more than just a mental health problem for an individual.~~ So it will take a coordinated and comprehensive response to ~~make sure we~~ prevent ~~as many of these~~further tragic and unnecessary deaths ~~as we can~~. Everyone has a role to play in these efforts and hope and healing is possible.
- Thank you. I'll turn it back to our moderator now.

Moderator: Thank you. (Operator's name), I believe we are ready for questions, please.

[Q&A]

Media Q&A –AFTER FINAL QUESTION- (Moderator): Thank you Drs. Schuchat, Adams and Stone for joining us today, as well as reporters. Further information is available on this topic through our Vital Signs website, www.cdc.gov/vitalsigns. For follow-up

questions, call the press office at 404-639-3286 or send an email to media@cdc.gov.

Thank you for joining us; this concludes our call.

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Sent: 13 May 2018 16:49:20 -0400
To: Black, Erin (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
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Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief
Attachments: TELEBRIEF SCRIPT_V4_pgm_LS_5.7.18_1.40pm_TS_LS_SO.5.11.18.EB+ac+EB (002).docx

Hi Erin,
Thank you for moving this forward. I suggested a few edits in the version attached. There are some additional points to make in the terms box at the top that I pulled from the definitions document. Deb, I added a note for you. Also, are there any other key points that you want to be sure are made?
Erin, in the summary you provided about next steps you indicated that there was a request to put the % who disclosed suicidal thoughts in the script. Was that really to go in the script? It seems more appropriate for the Q & A.
The answer would be that the % of suicide decedents who disclosed suicide intent was slightly higher among those with mental health problems (24.5%) compared to those without known mental health problems (22.5%).
-Tom

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Sent: Saturday, May 12, 2018 12:01 AM
To: Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
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Thanks Alex. I made your suggested edits in the attached. I also spoke to Tom and we decided to add the terminology guidance box and Air Force example. I did not add mention of the HP2020 goal, the % of people who told someone they were contemplating suicide or mention CDR Cunningham (since it hasn't been reported as a suicide I don' think we should proactively discuss during a suicide VS release) rather add a TP to the Q&As incase a question is asked. Please let me know what you all think.

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- DVP ADS Tom Simon: 4/24/18
- DVP Policy Malia Richmond-Crum: 4/23/18
- DVP SME Deb Stone: 4/19/18, 4/24/18
- DVP HCET Marie Ballman: 4/17/2018
- LS-OADC: 5/1/2018
- KSG-OADC: 5/4/2018

Suicide TerminologyReporting Guidelines	
Don't Do This	**Do This Instead**
Don't use sensationalistic ~~headlines~~	Do inform without ~~sensationalizing~~
~~Don't include photos/videos of the location, method, grieving family/friends, or memorials/funerals~~	~~Do use a school/work or family photo and include the lifeline number~~
Don't describe as an epidemic, skyrocketing, etc.	Do use the most recent CDC data and non-sensational works (rise, higher, etc.)
Don't use "without warning"	Do include the 'warning signs' and 'what to do' info in articles
~~Don't use "left a suicide note saying…"~~	~~Do indicate a note was found and is being reviewed~~
~~Don't investigate and report on suicide like reporting on crimes~~	~~Do report on suicide as a public health issue~~
~~Don't quote/interview first responders about the causes of suicide~~	~~Do seek advice from suicide prevention experts~~
Don't refer to suicide attempt as 'successful,' unsuccessful,' ~~'committed'~~ or 'failed attempt'	Do describe as "life lost to suicide"

mment [ST(]: I don't think you need include the points that are only evant for media reporting here. This is ant to give Dr. S and Adams a primer terms they should avoid. I deleted the ws I thought were not necessary. That d it would be good to include points for following from the definitions doc: her terms not to use include the lowing:

Completed suicide - Alternate m: suicide
ailed attempt - Alternate terms: suicide empt or suicidal self-directed violence. lonfatal suicide –Alternate term: cide attempt
uccessful suicide – Alternate term: cide.

Vital Signs Rising Suicide Rates Across U.S.

June 7, 2018

Desired Headlines

- Nearly 45,000 lives lost to suicide~~s occurred~~ in 2016, but suicide is preventable.
- Suicide rates ~~going~~ up in almost all states, but suicide is preventable.
- Suicide rates ~~s increased~~ went up more than 30% in half of U.S. states between 1999 and 2016.
- Many factors contribute to suicide, beyond mental health problems alone ~~contribute to suicide~~.

Moderator: Thank you (OPERATOR NAME). And thank you all for joining us today for the release of a new CDC Vital Signs report, ~~this one~~ on Circumstances and Trends in State Suicide Rates. We are joined by Dr. Anne Schuchat, CDC's Principal Deputy Director and the Surgeon General Dr. Jerome Adams. Dr. Deb Stone, one of the

authors of the study, is also available to help ~~with~~answer questions. Following remarks, we will respond to questions. I'd like to turn the call over now to Dr. Anne Schuchat.

Dr. Schuchat:

- Good afternoon and thank you for joining us today.
- CDC works 24/7 to protect Americans against health threats. Each month in CDC's *Vital Signs* report, **we focus on one of these threats – and what can be done about it**.
- Today's report contains ~~alarming~~ **new information about suicide, and the range of factors that contribute to it.**
- In 2016 alone, **45,000 people in the U.S. lost their lives to suicide.**
- W~~hat w~~e found ~~is~~ that **suicide rates have increased in nearly every state** across the nation – and suicide is ~~it's~~ one of just three leading causes of death that are on the rise.
- Suicide r**ates** have **increased among all age groups** younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14.

- ~~In 2016 alone, 45,000 people in the U.S. lost their lives to suicide. [ ] We've known that the suicide rates were steadily creeping up over the past 15 years.~~
-
- **These are ~~devastating~~ findings are unacceptable.** We know that every suicide is a tragedy for those individuals, their families, friends and colleagues, and communities.
- **~~But S~~suicide is ~~also is~~ a public health problem –** and unfortunately, our data show that problem is getting worse.
- For this *Vital Signs* report, we first analyzed data from the National Vital Statistics System to look at trends in suicide rates for all 50 states and Washington, D.C.
- We then looked at data from CDC's National Violent Death Reporting System, covering 27 states in 2015, ~~and~~ to examine~~d~~ circumstances around suicides among people with and without known mental health problems. I'd like to take this opportunity to thank Congress for providing funding in the fiscal year 2018 omnibus to expand the system to all 50 states and the District of Columbia. CDC is actively working toward that goal.
-

Comment [ST(]: I would take this out of script for Dr. S since it is not a primary finding.

Comment [BE(]: Please check this is accurate.

Comment [CA]: I suggest avoiding the dramatic words

Comment [ST(]: Do you think this is what she had in mind? It seems a bit off to make this point here like this.

- **Suicide is often attributed solely to a mental health problem. But fewer than half of the people ~~who die by~~lost their life to suicide have a known mental health problem – and in many of these cases, other factors are involved.**
- In fact, our research found that people who lost their life to ~~died by~~ suicide and *did not* have a diagnosed mental health problem were somewhat more likely than those *with* a mental health problem to struggle with **relationship problems or loss, life stressors** and **recent or impending crises**. However, and **importantly**, these circumstances were common to both groups.
- **Suicide IS preventable.** ~~For example, The *United States Air Force Suicide Prevention Program*, including 11 policy and education initiatives, shifted the culture if the Air Force from viewing suicide and mental illness solely as medical problems and instead as larger service-wide problems impacting the whole community. The program was associated with a 33% relative risk reduction in suicide.~~
- That's why it's so important to know the full range of factors that contribute to suicide risk including relationship problems, substance use, physical and mental health, job issues, financial trouble, and legal problems.
- This information can be used to develop a comprehensive approach to prevention. For example, The United States Air Force Suicide Prevention Program, including 11 policy and education initiatives, shifted the culture of the Air Force from viewing suicide and mental illness solely as medical problems and instead as

Comment [ST(]: I feel like some transition is needed before introducing this. I move it down after a point about a comprehensive approach. What do you think of this?

larger service-wide problems impacting the whole community. The program was associated with a 33% relative risk reduction in suicide.

-
-
- ~~Expanded~~ Increased awareness of the range of circumstances contributing to suicide risk, and what action is needed to address them, can help the nation reach its goal of reducing the annual suicide rate 20 percent by 2025.
- Today's report suggests we have important work to do to reach this goal. Nearly **all states had increasing suicide rates between 1999 and 2016, and 25 states experienced rate increases of more than 30 percent.**
- So how do we work together to reverse these numbers and help save lives?

-
- Close coordination of activities between public health agencies and other sectors of society is critical for preventing suicide. Necessary partners include health-care and mental health providers; social services; ~~law enforcement~~first responders; educators; faith communities; businesses; and the media.
- States and communities **can and should take action now** based on the best available evidence.
- To help prioritize prevention efforts, we've developed *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* It features the best available

evidence for states and communities to guide their prevention priorities. The link to the technical package is on our *Vital Signs* website.

- **Preventing suicide involves everyone. Parents, employers, teachers, coaches, religious leaders – everyone in the community** can learn the warning signs of suicide, and how best to respond and get help.
- Now I'm going to turn it over to Dr. Adams for more discussion about suicide.

Dr. Adams:

- Thank you, Rear Admiral Anne Schuchat. As the nation's doctor, I am grateful for CDC's important work on this public health problem~~crisis~~.

- As Dr. Schuchat noted, suicide is a ~~devastating~~ serious national problem. It's simply not acceptable that we are now losing nearly 45,000 lives a year to suicide in this country, many of whom are military members or veterans.
- On the Federal level, government agencies are tracking the problem of suicide to understand trends and groups at greatest risk. We are developing, implementing, and evaluating what works to prevent suicide in communities. And we are working with public and private partners to advance the National Strategy for Suicide Prevention.

- The good news is that there are opportunities for prevention. This *Vital Signs* report reminds us that health care systems and providers have important roles to play in preventing the risk of suicide. Some specific things healthcare providers can do:
    - First, you can help make sure there are systems in place to screen, assess, and support people at risk, per clinical guidelines. And you can train staff ~~in suicide care,~~ practices, and protocols, including safety planning.
    -
    - Second, you can talk with people who are at risk – and their families – about how to safely store lethal means such as medications and firearms.
    - Finally, it is important to integrate and coordinate physical and behavioral/mental health care in ways that keep patients safe and engaged in care.
- Today's report shows that there are many factors that contribute to suicide risk. Everyone has a responsibility to help stop this alarming trend.
- **Thank you, I'll turn it back to Dr. Schuchat now.**

Dr. Schuchat:

Comment [ST(]: Deb, "suicide care" is unclear. We could just drop this and leave the rest or is there something else you would suggest adding here?

- **Thank you for your comments, Dr. Adams.**

- The bottom line is that many factors contribute to suicide. It's a lot more than just a mental health problem for an individual. So it will take a coordinated and comprehensive response to make sure we prevent as many of these tragic and unnecessary deaths as we can. Everyone has a role to play in these efforts.
- Thank you. I'll turn it back to our moderator now.

Moderator: Thank you. (Operator's name), I believe we are ready for questions, please.

[Q&A]

Media Q&A –AFTER FINAL QUESTION- (Moderator): Thank you Drs. Schuchat, Adams and Stone for joining us today, as well as reporters. Further information is available on this topic through our Vital Signs website, www.cdc.gov/vitalsigns. For follow-up questions, call the press office at 404-639-3286 or send an email to media@cdc.gov.

Thank you for joining us; this concludes our call.

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 12 May 2018 00:00:51 -0400
To: Crosby, Alexander (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief
Attachments: TELEBRIEF SCRIPT_V4_pgm_LS_5.7.18_1.40pm_TS_LS_SO.5.11.18.EB+ac+EB.docx

Thanks Alex. I made your suggested edits in the attached. I also spoke to Tom and we decided to add the terminology guidance box and Air Force example. I did not add mention of the HP2020 goal, the % of people who told someone they were contemplating suicide or mention CDR Cunningham (since it hasn't been reported as a suicide I don' think we should proactively discuss during a suicide VS release) rather add a TP to the Q&As incase a question is asked. Please let me know what you all think.

From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 6:15 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: Re: Vital Signs FS and press release with modifications after the Pre-Brief

Greetings:
I have attached my comments. Pretty minor just some word choices.
Alex C
Sent from my BlackBerry 10 smartphone.

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, May 11, 2018 15:18
To: Simon, Thomas (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC); Kegler, Scott R. (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Yuan, Keming (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC); Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Bruce, Crystal (CDC/OPHPR/OD); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Ballman, Marie R. (CDC/ONDIEH/NCIPC); Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs FS and press release with modifications after the Pre-Brief

All – wanted to get your thoughts on the script for Dr. S.
In working through the document, I made these updates:

- Updated the headlines based on comments today.
- Added a reference to thank congress for funding to expand NVDRS.
- Removed the reference to 'suicide care'.
- Added reference to age-specific rates overtime (but not the other sited work mentioned)
- Added percent of those that died by suicide who were military/vets (It seems weird to specifically call this out in the script but per Anne's request, let me know your thoughts).

Let me know your thoughts about the following that were discussed in the pre-brief– I think these are more appropriate in the Q&As than the script:

- Terminology guidance box – Added to the script
- HP2020 goal
- Air force example – Added to the script
- % of people who told someone they were contemplating suicide
- Mention of CDR Cunningham (I don't think it is confirmed he died by suicide, rather drowning)

Current version of the script is attached, let me know what you think. I hope to send to Leslie to take a quick look before sending back to the VS office COB Monday. Still waiting for edits from the SG's office on his piece – I sent them a reminder.

E

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 10, 2018 6:00 PM
To: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Cc: Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: Vital Signs FS and press release with modifications after the Pre-Brief

Hi VS team,

We really appreciated all the helpful feedback provided during the pre-brief with Dr. Schuchat. We also appreciate the guidance you provided before and after. The ideas that the graphics team provided for page 3 during the call yesterday seem like they will be helpful. We look forward to seeing the new version.

We are attaching a copy of the fact sheet pdf with embedded stickies to describe specific edits. These reflect the changes we discussed during and after the pre-brief. I'm also attaching a Word document that describes the changes that we discussed for page 3 during the call yesterday. We are providing shortened text for the figure that was at the top of page 3. I understand that this will be formatted using the new layout but we edited the text in the old format so you can see how it relates. Please use this new text. This document also provides the 5 steps to go on the bottom right of page 3 and some other specific edits to the title and warning signs text.

We are also attaching the press release with a few edits. We were reflecting on Dr. Schuchat's concern about small states and whether the increase could be based on a small number of suicides. Scott looked into this for us and we are comfortable that these are meaningful increases. He prepared a helpful Q & A about this (attached). Given this, we think it is ok to keep the text in the press release about the ranges across states. I wanted to mention this to you though in case you want to consult with Dr. Schuchat about this given the questions she raised.

Finally, regarding the request to reflect how the increases in suicide rates have varied across age group, we are proposing the addition of the following highlighted text to the introductory paragraph. Can you please check to see if this is consistent with what Dr. Schuchat would like?

BACKGROUND AND PURPOSE

In 2016, nearly 45,000 suicides (15.6/100,000 population [age-adjusted]) occurred in the United States among persons aged ≥10 years (1). Between 1999 and 2015, suicide rates increased among both sexes, all racial/ethnic groups, and all urbanization levels (2,3). Suicide rates have increased among all age groups younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14 (3). Suicide is the 10th leading cause of death and is one of just three leading causes that are increasing (1,4). Additionally, rates of emergency department visits for nonfatal self-harm, a key risk factor for suicide, increased 42% between 2001 and 2015 (1). Together, suicides and self-harm injuries cost the nation more than $69 billion in direct medical and work loss costs (1).

Thank you!

Tom, Deb, and our VS team

Telebrief Script_V3_pgm_LS_NMB_5072018_952am

Review Tracker

- NCIPC OC Leslie Dorigo: 4/25/18
- DVP ADS Tom Simon: 4/24/18
- DVP Policy Malia Richmond-Crum: 4/23/18
- DVP SME Deb Stone: 4/19/18, 4/24/18
- DVP HCET Marie Ballman: 4/17/2018
- LS-OADC: 5/1/2018
- KSG-OADC: 5/4/2018

Suicide Reporting Guidelines	
Don't Do This	**Do This Instead**
Don't use sensationalistic headlines	Do inform without sensationalizing
Don't include photos/videos of the location, method, grieving family/friends, or memorials/funerals	Do use a school/work or family photo and include the lifeline number
Don't describe as an epidemic, skyrocketing, etc.	Do use the most recent CDC data and non-sensational works (rise, higher, etc.)
Don't use "without warning"	Do include the 'warning signs' and 'what to do' info in articles
Don't use "left a suicide note saying..."	Do indicate a note was found and is being reviewed
Don't investigate and report on suicide like reporting on crimes	Do report on suicide as a public health issue
Don't quote/interview first responders about the causes of suicide	Do seek advice from suicide prevention experts
Don't refer to suicide as 'successful,' unsuccessful,' 'committed' or 'failed attempt'	Do describe as "life lost to suicide"

Vital Signs Rising Suicide Rates Across U.S.

June 7, 2018

Desired Headlines

- Nearly 45,000 lives lost to suicide~~s occurred~~ in 2016, but suicide is preventable.
- Suicide rates ~~going~~ up in almost all states, but suicide is preventable.
- Suicide rates ~~s increased~~ went up more than 30% in half of U.S. states between 1999 and 2016.
- Many factors contribute to suicide, beyond mental health problems alone ~~contribute to suicide~~.

Moderator: Thank you (OPERATOR NAME). And thank you all for joining us today for the release of a new CDC Vital Signs report~~, this one~~ on Circumstances and Trends in State Suicide Rates. We are joined by Dr. Anne Schuchat, CDC's Principal Deputy Director and the Surgeon General Dr. Jerome Adams. Dr. Deb Stone, one of the

authors of the study, is also available to ~~help with~~answer questions. Following remarks, we will respond to questions. I'd like to turn the call over now to Dr. Anne Schuchat.

Dr. Schuchat:

- Good afternoon and thank you for joining us today.
- CDC works 24/7 to protect Americans against health threats. Each month in CDC's *Vital Signs* report, **we focus on one of these threats – and what can be done about it**.
- Today's report contains ~~alarming~~ **new information about suicide, and the range of factors that contribute to it.**
- In 2016 alone, **45,000 people in the U.S. lost their lives to suicide.**
- W~~hat w~~e found ~~is~~ that **suicide rates have increased in nearly every state** across the nation – and it's one of just three leading causes of death that are on the rise.
- **Rates increased among all age groups** younger than 75 years, with the highest percent increases among those aged 45-64 and those aged 10-14.
- In 2016 alone, **45,000 people in the U.S. lost their lives to suicide.** 17.8% of those who died by suicide were **currently serving or ever served in the military.**

Comment |BE(|: Please check this is accurate.

-
- **These are ~~devastating~~ findings are unacceptable.** We know that every suicide is a tragedy for those individuals, their families, friends and colleagues, and communities.
- **~~But~~ Ssuicide is ~~also is~~ a public health problem –** and unfortunately, our data show that problem is getting worse.
- For this *Vital Signs* report, we first analyzed data from the National Vital Statistics System to look at trends in suicide rates for all 50 states and Washington, D.C.
- We then looked at data from CDC's National Violent Death Reporting System, covering 27 states in 2015, ~~and~~ to examine~~d~~ circumstances around suicides among people with and without known mental health problems. I'd like to take this opportunity to thank Congress for providing funding in the fiscal year 2018 omnibus to expand the system to all 50 states and the District of Columbia. CDC is actively working toward that goal.
-
- **Suicide is often attributed solely to a mental health problem. But fewer than half of the people ~~who die by~~lost their life to suicide have a known mental health problem – and in many of these cases, other factors are involved.**

Comment [CA]: I suggest avoiding the dramatic words

- In fact, our research found that people who lost their life to ~~died by~~ suicide and *did not* have a diagnosed mental health problem were somewhat more likely than those *with* a mental health problem to struggle with **relationship problems or loss, life stressors** and **recent or impending crises**. However, and **importantly**, these circumstances were common to both groups.
- **Suicide IS preventable.** For example, The *United States Air Force Suicide Prevention Program,* including 11 policy and education initiatives, shifted the culture if the Air Force from viewing suicide and mental illness solely as medical problems and instead as larger service-wide problems impacting the whole community. The program was associated with a 33% relative risk reduction in suicide.
- ~~That's why I~~it's so important to know the full range of factors that contribute to suicide risk including relationship problems, substance use, physical and mental health, job issues, financial trouble, and legal problems.
-
- ~~Expanded~~ Increased awareness of the range of circumstances contributing to suicide risk, and what action is needed to address them, can help the nation reach its goal of reducing the annual suicide rate 20 percent by 2025.

- Today's report suggests we have important work to do to reach this goal. Nearly **all states had increasing suicide rates between 1999 and 2016, and 25 states experienced rate increases of more than 30 percent.**
- So how do we work together to reverse these numbers and help save lives?
-
- Close coordination of activities between public health agencies and other sectors of society is critical for preventing suicide. Necessary partners include health-care and mental health providers; social services; ~~law enforcement~~first responders; educators; faith communities; businesses; and the media.
- States and communities **can and should take action now** based on the best available evidence.
- To help prioritize prevention efforts, we've developed *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* It features the best available evidence for states and communities to guide their prevention priorities. The link to the technical package is on our *Vital Signs* website.
- **Preventing suicide involves everyone. Parents, employers, teachers, coaches, religious leaders – everyone in the community** can learn the warning signs of suicide, and how best to respond and get help.
- Now I'm going to turn it over to Dr. Adams for more discussion about suicide.

Dr. Adams:

- Thank you, Rear Admiral Anne Schuchat. As the nation's doctor, I am grateful for CDC's important work on this public health crisis.

  - As Dr. Schuchat noted, suicide is a ~~devastating~~ serious national problem. It's simply not acceptable that we are now losing nearly 45,000 lives a year to suicide in this country, many of whom are military members or veterans.
  - On the Federal level, government agencies are tracking the problem of suicide to understand trends and groups at greatest risk. We are developing, implementing, and evaluating what works to prevent suicide in communities. And we are working with public and private partners to advance the National Strategy for Suicide Prevention.
  - The good news is that there are opportunities for prevention. This *Vital Signs* report reminds us that health care systems and providers have important roles to play in preventing the risk of suicide. Some specific things healthcare providers can do:
    - First, you can help make sure there are systems in place to screen, assess, and support people at risk, per clinical guidelines. And you can

train staff in ~~suicide~~ care, practices, and protocols, including safety planning.

-
- Second, you can talk with people who are at risk – and their families – about how to safely store lethal means such as medications and firearms.
- Finally, it is important to integrate and coordinate physical and behavioral/mental health care in ways that keep patients safe and engaged in care.

- Today's report shows that there are many factors that contribute to suicide risk. Everyone has a responsibility to help stop this alarming trend.
- **Thank you, I'll turn it back to Dr. Schuchat now.**

Dr. Schuchat:

- **Thank you for your comments, Dr. Adams.**

- The bottom line is that many factors contribute to suicide. It's a lot more than just a mental health problem for an individual. So it will take a coordinated and comprehensive response to make sure we prevent as many of these tragic and unnecessary deaths as we can. Everyone has a role to play in these efforts.
- Thank you. I'll turn it back to our moderator now.

Moderator: Thank you. (Operator's name), I believe we are ready for questions, please.

[Q&A]

Media Q&A –AFTER FINAL QUESTION- (Moderator): Thank you Drs. Schuchat, Adams and Stone for joining us today, as well as reporters. Further information is available on this topic through our Vital Signs website, www.cdc.gov/vitalsigns. For follow-up questions, call the press office at 404-639-3286 or send an email to media@cdc.gov.

Thank you for joining us; this concludes our call.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 11:21:07 +0000
To: Lenard, Courtney (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC);Lane, Gabraelle (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Interview Readout

Thank you, Courtney, Alex and Kristin and Tom and I will make sure we have answers to these questions! Many can be gotten or gleaned from the Q&A but some are obviously new. Very good questions!!
Deb

From: Lenard, Courtney (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 7:00 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Eschelbach, Julie (CDC/ONDIEH/NCIPC) ; Lane, Gabraelle (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Daniel, Valerie M. (CDC/ONDIEH/NCIPC)
Subject: Fw: Vital Signs Interview Readout
FYI

Sent from my BlackBerry 10 smartphone.

From: Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>
Sent: Wednesday, June 6, 2018 6:48 PM
To: Lenard, Courtney (CDC/ONDIEH/NCIPC); Dorigo, Leslie (CDC/ONDIEH/NCIPC); Sokler, Lynn (CDC/OD/OADC); Harben, Kathy (CDC/OD/OADC); Omisore, Shannon L. (CDC/OD/OADC); Burden, Bernadette (CDC/OD/OADC)
Subject: Vital Signs Interview Readout

Just wanted to let you know that Dr. Schuchat did phone interviews today with CNN, TIME, Washington Post, AP and NBC News (online). I wanted to share some of the questions, as they could help with prep for the telebriefing.

Overall – there were a lot of questions about what is driving the increase and why it's worse in certain states/regions, or rising among certain groups (women, veterans, etc.) Several asked about concerns of copycat incidents following the Kate Spade news, and questioned whether today's culture/environment play a role. The list below captures a lot of it, but let me know if you have any questions.

1) What's new here? What does this report reveal that's not already out there?
2) Was anything in this report particularly surprising to you/CDC?
3) What is CDC trying to achieve by looking more closely at these numbers?
4) Can you explain why there has been a sustained upswing in the suicide rate in recent years?
5) Beyond these findings – what is going on in our country? Is today's culture (hate speech, social media, anxiety) driving this trend?
6) Were you surprised at the number of people who died from suicide who did not have known mental health conditions?

7) Increasing access to mental health has often been cited as key to suicide prevention. How does the finding that many don't have a mental health problem complicate this strategy?
8) Clinical depression, loneliness, anxiety are all up. Are these factors contributing to the increased rates of suicide?
9) How do you define someone with mental health conditions? Do they have to be diagnosed by a mental health practitioner?
10) If many of them didn't have a known mental health condition, how do we identify, reach and help them?
11) Can you provide more insight on why we're seeing increases among (rural areas/Western states/women)?
12) Do you have more information on veterans and the burden of suicide among this group?
13) Are medically-assisted suicides included in this report?
14) Is there a reason why suicide by firearms is higher for people who didn't have a known mental health diagnosis?
15) Can you describe what "left a note" means in the (MMWR) table. Does that mean one-third of all people who committed suicides left a note? Is that consistent with what's been reported before?
16) What does your prevention strategy look like?
17) What are the main steps to getting people help early?
18) Do Kate Spade and other high profile suicides make you worry about copycats?

Kate Grusich
Public Affairs Specialist
CDC News Media Branch
(o) 770-488-3337
(c) 404-414-7070

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 4 Jun 2018 15:48:35 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Suicide Materials

Some were just for you to consider.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 3:47 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Suicide Materials

Thanks, Tom! I'll send those edits forward.
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 3:30 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: Vital Signs Suicide Materials

Hi Deb,
I made a few edits to the script for you to consider, including some edits to the NVDRS text about the 40 states.
I did not see any edits to the email.
See below for other suggestions for responses.
-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Monday, June 4, 2018 1:42 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: FW: Vital Signs Suicide Materials

Hi Tom,
Please see attached edits on telebrief script. Just awaiting the reply on NVDRS and then I'll send back if you are ok with my replies.
Deb

From: Hoo, Elizabeth (CDC/OD/PPEO)
Sent: Monday, June 4, 2018 1:00 PM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>
Cc: Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Gaines-McCollom, Molly (CDC/OPHPR/DEO) <iwg9@cdc.gov>; Kroop, Seth (CDC/OD/OCS) <wpw7@cdc.gov>; Roberts, Ursula (CDC/OD/OCS) (CTR) <nka7@cdc.gov>
Subject: RE: Vital Signs Suicide Materials

Hi Lynn and Deb,
I have a few clarifying questions from Dr. Schuchat on the documents:

- In the MMWR article, Introduction: "Suicide is the 10th leading cause of death and is one of just three leading causes that are increasing (*1*,*4*)."
  - Is this still true? Yes
  - What are the other two causes that are increasing? Deaths from unintentional injuries and Alzheimer's disease.

- In the telebrief script:
  - Why are western states increasing? We don't highlight western states in the telebriefing script. The increases are happening across the country. Western rates have, and continue to have, relatively high suicide rates. Deb, do you have a q and a about this already that you can draw from (e.g., social isolation, access to services, etc)?
  - There are a few more comments/questions in the telebrief script for you to review.

I made a few changes to the telebrief script and critical contacts letter. Those are both attached.
Thanks,
Liz

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Friday, June 1, 2018 2:35 PM
To: Roberts, Ursula (CDC/OD/OCS) (CTR) <nka7@cdc.gov>; Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>
Cc: Hoo, Elizabeth (CDC/OD/PPEO) <irp5@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Gaines-McCollom, Molly (CDC/OPHPR/DEO) <iwg9@cdc.gov>
Subject: Vital Signs Suicide Materials

Hi Anne,
Attached are the materials for your review over the weekend. These include:

- Telebrief script – revised since Dr. Adams will not be participating
- MMWR proof
- Fact Sheet – cleared by ASPA. Program making minor tweaks
- Press Release – cleared by ASPA.
- QA document - revised

The **Critical Contacts** email for Anne to send out at 9 am on June 7 (launch day) is also attached. I will send final materials to everyone on Wednesday that should accompany the Critical Contacts email.
Also provided here is a brief summary of two recent updates from program, for Anne to be aware of:
The first update is related to the inclusion of the QuickStat on youth homicide and suicide trends in the same MMWR issue as the Vital Signs article. We think this could cause the media to focus on youth suicide whereas the Vital Signs MMWR emphasizes the increases across all age groups under age 75. If questions are asked about the QuickStat it will be helpful to acknowledge the increasing rates among youth and point out that suicide rates are increasing across all age groups younger than age 75. For example, middle aged adults have the largest number of suicides and have seen particularly high increases in rates. We provide a Q&A on this that bridges back to the Vital Signs MMWR and the need for prevention across the lifespan.
The second update is related to how the presence of a known mental health condition is measured in NVDRS. ASPE requested a citation in the fact sheet to clarify that not having a known diagnosis does not necessarily mean that there was no mental illness. We added text from the MWMR to the fact sheet to explain the data sources and that it is possible that mental health conditions could have been present and not diagnosed, known, or reported. This is important because the NVDRS defines a mental health condition as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, with the exception of alcohol and other substance use problems, which are captured separately in the system. The NVDRs data are from coroner/medical examiner and law enforcement reports, which reflect information provided by family and friends. Estimates about the extent to which suicide decedents have mental health conditions vary. Some studies include extensive record reviews

and in-depth interviews with next-of-kin about history and symptoms. A commonly reported statistic using this psychological autopsy approach is that 90% of suicides involve a mental illness or substance use disorder. The NVDRS estimate is of current diagnosed mental health conditions. Problematic substance use and perceptions about current depressed mood are assessed separately. In the relevant Q&A, we acknowledge that some decedents might have mental health conditions that were not diagnosed or reported. We emphasize that the high prevalence of diverse contributing circumstances among those with and without known mental health conditions suggests the importance of addressing the broad range of factors that contribute to suicide.

Thanks, Lynn

From: Roberts, Ursula (CDC/OD/OCS) (CTR)
Sent: Thursday, May 31, 2018 10:24 AM
To: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>
Cc: Hoo, Elizabeth (CDC/OD/PPEO) <irp5@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
Subject: RE: Suicide VS

Tomorrow will be fine..
Thanks Lynn!
Ursula

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Thursday, May 31, 2018 9:58 AM
To: Roberts, Ursula (CDC/OD/OCS) (CTR) <nka7@cdc.gov>
Cc: Hoo, Elizabeth (CDC/OD/PPEO) <irp5@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>
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Hi Ursula, we're just completing the materials to go back to HHS today. Does she need today or will tomorrow work? We don't have revised telebrief script until tomorrow either. And not sure if we are still including SG or not.
Let us know when she needs and Shannon will forward to you and Elizabeth.
Thanks, Lynn

Sent from my iPhone

On May 31, 2018, at 9:53 AM, Roberts, Ursula (CDC/OD/OCS) (CTR) <nka7@cdc.gov> wrote:

> Hi Lynn,
> Hope you had a great holiday weekend!
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From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 4 Jun 2018 15:29:56 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Suicide Materials
Attachments: TELEBRIEF SCRIPT_V5_pgm_06.1.18_9.15am_revAS_comments_06.04.18_12.49pm ds.docx

Hi Deb,
I made a few edits to the script for you to consider, including some edits to the NVDRS text about the 40 states.
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> Ursula

Telebrief Script_V4_pgm_DS_ 5172018_1045am

Review Tracker

- NCIPC OC Leslie Dorigo: 4/25/18
- DVP ADS Tom Simon: 4/24/18
- DVP Policy Malia Richmond-Crum: 4/23/18
- DVP SME Deb Stone: 4/19/18, 4/24/18, 5/13 5/17, 6/1
- DVP HCET Marie Ballman: 4/17/2018
- LS-OADC: 5/1/2018
- KSG-OADC: 5/4/2018

Suicide Terminology	
Don't Do This	**Do This Instead**
Don't use sensationalistic headlines (e.g., Kurt Cobain used shotgun to commit suicide)	Do inform without sensationalizing (e.g. ~~Curt~~ Kurt Cobain dead at 27)
Don't describe suicide as an epidemic, skyrocketing, etc.	Do use the most recent CDC data and non-sensational words (rise, higher, etc.)
Don't describe suicide as inexplicable or "without warning"	Do include the 'warning signs' and 'what to do' info in articles
Don't refer to suicides or attempts as 'successful' or 'completed'	Describe as suicide, person died by suicide, or life lost to suicide
Don't refer to suicide attempts as 'unsuccessful,' 'failed attempt' or 'nonfatal suicide'	Describe as 'suicide attempt' or 'suicidal self-directed violence'
Don't use 'committed' suicide because this invokes the idea of a crime	Describe as died by suicide

Comment [zaf9]: This should really stay since state trends are what we are oking at specifically.

omment [ST(]: I think this is ok to drop re since Dr. S gets right into the state nds.

Vital Signs Rising Suicide Rates Across U.S.

June 7, 2018

Desired Headlines

- Nearly 45,000 lives lost to suicide in 2016, but suicide is preventable.
- Suicide rates up in almost all states, but suicide is preventable.
- Suicide rates went up more than 30% in half of U.S. states between 1999 and 2016.
- Many factors contribute to suicide, beyond mental health conditions alone.

Moderator: Thank you (OPERATOR NAME). And thank you all for joining us today for the release of a new CDC Vital Signs report on Trends in ~~State~~ Suicide Rates and contributing circumstances to suicide. We are joined by Dr. Anne Schuchat, CDC's Principal Deputy Director and Dr. Deb Stone, lead author of the study, to help answer questions. Following remarks, we will respond to questions. I'd like to turn the call over now to Dr. Anne Schuchat.

Dr. Schuchat:

- Good afternoon and thank you for joining us today.
- CDC works 24/7 to protect Americans against health threats. Each month in CDC's *Vital Signs* report, **we focus on one of these threats – and what can be done about it**.
- Today's report contains **new information about state suicide trends, the factors that contribute to suicide, and the implications for prevention.**
- In 2016 alone, **45,000 people in the U.S. lost their lives to suicide.**
- Suicide is one of just three leading causes of death that are on the rise.
- Each suicide greatly impacts families, friends, and entire communities.
- **Between 1999 and 2016, suicide rates increased among all age groups** younger than 75 years. For example, middle-aged adults have the largest number of suicides and have seen particularly high increases in rates.
- We found that **suicide rates increased in nearly every state** across the nation.
- **These findings are ~~unacceptable~~disturbing.**
- **Suicide is a preventable public health problem –** and unfortunately, our data show that the problem is getting worse.
- For this *Vital Signs* report, we first analyzed data from the National Vital Statistics System to look at trends in suicide rates for all 50 states and Washington, D.C.

- We then looked at data from CDC's National Violent Death Reporting System, covering 27 states in 2015, and examined circumstances around suicides among people with and without known mental health conditions.
    - [As a side note, CDC is now collecting data in 40 ~~in the coming year CDC will have report data for 40~~ states, D.C. and Puerto Rico, and thanks to Congress for providing funding in the fiscal year 2018 omnibus, CDC is working to expand the system to all 50 states].
- **Suicide is often attributed solely to a mental health concern. But, according to NVDRS, fewer than half of the people who lost their life to suicide had a known mental health condition.** ~~– and in many of these cases, other factors were also involvedevident.~~
- Our research found that those people who died by suicide and *did not* have a diagnosed mental health condition were somewhat more likely than those *with* a mental health condition to struggle with **relationship problems or loss, other life stressors** and experience **recent or impending crises**. However, perhaps more **importantly**, these circumstances were common to both groups regardless of mental health conditions.
- **Suicide IS preventable.**

Comment [HE(]: What year is this for? 2016 data or future? Clarify what year of data this refers to.

Comment [ST(]: CDC is collecting data in 40 states starting in 2017. These data will start to become available in the fall of 2019.

Comment [HE(]: Which cases? Those who do have a mental health condition?

Comment [zaf9]: We can delete this sentence since the next bullet point gets into what we mean.

Comment [HE(]: General question: Is suicide cyclical? Does it go up and down? Related to economy?

Comment [zaf9]: Yes, suicide tends to decrease with economic expansions and increase in times of economic contractions.

- That's why it's so important to understand the range of factors and circumstances that contribute to suicide risk including **relationship problems, substance misuse, physical and mental health conditions, job issues, financial troubles, and legal problems.**
- With this information in mind, states and communities can develop a comprehensive approach to suicide prevention. One example of a successful program is The United States Air Force Suicide Prevention Program. This program, inclusive of 11 policy and education initiatives geared broadly towards increasing social support, social skills, and help-seeking, shifted the culture of the Air Force away from viewing suicide as an individual-oriented mental health concern to a larger service-wide problem impacting the whole community. The program was associated with a 33% relative risk reduction in suicide as well as reductions in other related problems, such as severe family violence (54%) and homicide (51%).
- Increased awareness of the range of circumstances contributing to suicide risk, and the need to address them through such a comprehensive approach, can help the nation reach its goal of reducing the annual suicide rate 20 percent by 2025.
- Today's report suggests we have a lot of important work to do to reach this goal. Nearly **all states had increasing suicide rates between 1999 and 2016, and 25 states experienced rate increases of more than 30 percent.**

Comment [HE(]: What other related problems?

- So how do we work together to reverse these numbers and help save lives?
- **On the Federal level, government agencies are tracking the problem of suicide to understand trends and groups at greatest risk;** developing, implementing, and evaluating what works to prevent suicide in communities; we are supporting local, state, tribal, and other partners to prevent suicide; and we are working with public and private partners to advance the **National Strategy for Suicide Prevention.**
- In states and communities, close coordination of activities between public health agencies and other sectors of society is critical for preventing suicide. Necessary partners include health and mental healthcare providers, social services, first responders, educators, faith communities, and the media.
- States and communities **can and should take action now**.
- To help prioritize prevention efforts, CDC developed *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* It features the best available evidence for states and communities to guide their prevention activities.
- Some of the strategies are designed to prevent suicide risk before it emerges in the first place. These strategies include teaching coping and problem-solving skills to help people manage life challenges; promoting safe and supportive environments, including safe storage of medications and firearms among people

at risk; providing temporary help for people struggling to make ends meet, and encouraging connectedness so people are less likely to feel alone or isolated.

- Other strategies in the technical package seek to support people who may already be struggling, for example, through the provision of effective treatment and crisis intervention strategies. Health and behavioral health care providers have an important role to play in suicide prevention as well, so that nobody in these systems falls through the cracks. Policies and protocols that prioritize patient safety and that engage people in ongoing care, especially during care transitions, can help prevent suicide.

- Last and very important, the technical package describes approaches to prevent future suicide risk among those who have attempted or lost a friend or loved one to suicide.

- The link to the technical package is on our *Vital Signs* website.
- **Preventing suicide involves everyone. Parents, employers, teachers, coaches, religious leaders, providers, and people affected by suicide – everyone in the community** can help prevent suicide risk by learning the warning signs of suicide, and how best to respond effectively. Together we can bring hope and save lives.

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: 16 May 2018 07:20:40 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs Workgroup Meeting
Attachments: 18_292322-A_Sokler_June_2018_Suicide_v7_05.16.18._6.38am_BP LD_CB.pdf, Suicide Word FS_V7_5.16.18_6.49am_pgm_BP_SO_BP_CB.DOCX

Hi Deb and Kristin,
Per our meeting yesterday, I'm sending my feedback on the latest version of the FS to you. I brainstormed with Marie and Leslie so we combined our feedback. I put sticky notes on the PDF for graphic changes and track changes in the Word doc for text changes, but here is a summary of the graphic recommendations:

Page 2, bottom graphic:
Recommend replacing center of graphic with text – 'Suicide'
Page 3, left side graphic:
Recommend extending the banners and including the icons inside the banners

The text changes are in track changes. Let me know if you have any questions. Thanks!
Crystal

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, May 15, 2018 7:03 PM
To: Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: Vital Signs Workgroup Meeting
Thanks, I'll let you know. Hopefully we can resolve tomorrow a.m.
Deb

From: Bruce, Crystal (CDC/OPHPR/OD)
Sent: Tuesday, May 15, 2018 1:52 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>
Cc: Daniel, Valerie M. (CDC/ONDIEH/NCIPC) <guh8@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Massetti, Greta M. (CDC/ONDIEH/NCIPC) <ghz6@cdc.gov>
Subject: RE: Vital Signs Workgroup Meeting
Hi all,
Here is the telebriefing script with only the SG's talking points. Let me know how you think we should proceed with these – should they be incorporated into the script Erin sent forward yesterday, or should we send them in a separate email (after you all review)?
Crystal
-----Original Appointment-----
From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Tuesday, January 9, 2018 1:23 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Bruce, Crystal (CDC/OPHPR/OD); Simon, Thomas (CDC/ONDIEH/NCIPC); Kegler, Scott R. (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Yuan, Keming (CDC/ONDIEH/NCIPC); Holland, Kristin

(CDC/ONDIEH/NCIPC); Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC); Black, Erin (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Cc: Daniel, Valerie M. (CDC/ONDIEH/NCIPC); Ballman, Marie R. (CDC/ONDIEH/NCIPC); Massetti, Greta M. (CDC/ONDIEH/NCIPC)
Subject: Vital Signs Workgroup Meeting
When: Tuesday, May 15, 2018 12:00 PM-1:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: 10A
5/15/18
Updating zip file with latest fact sheet and supplementary table 1 which should have also been in there. Keep in mind that many of the items in the file are still undergoing revision.
5/14
Attaching materials for tomorrow.
As always there are a lot of materials but just providing most up to date versions to keep everyone in the loop.
Awaiting FS from Vital Signs that is arriving 5.15.18 a.m. Will add it here when I get it, hopefully well before meeting.
Also, if someone can sub in for Erin where her name appears in the agenda, that would be great.
Thanks!
Deb

VS_v6_05/15/18_10:30 A.M.

#vitalsigns
JUN 2018

CDC Vitalsigns™

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of US states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.



Want to learn more?
Visit: www.cdc.gov/vitalsigns

Suicide rising across the US

More than just a mental health condition

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as relationship problems or loss, substance use disorders, physical health problems, and job, money, legal, or housing stress. Government, public health, healthcare, business, education, media and community organizations working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Hold activities that bring people together so that they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control



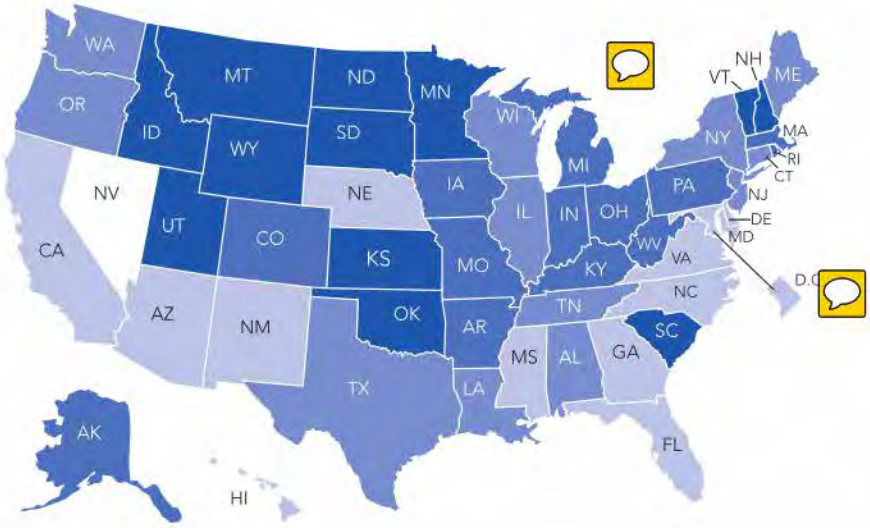
PROBLEM:

Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.

Increase	38 - 58%
Increase	32 - 37%
Increase	19 - 29%
Increase	6 - 18%
Decrease	1%

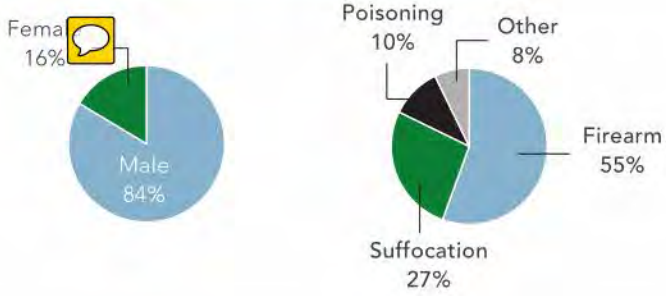
SOURCE: *CDC's National Vital Statistics System.*



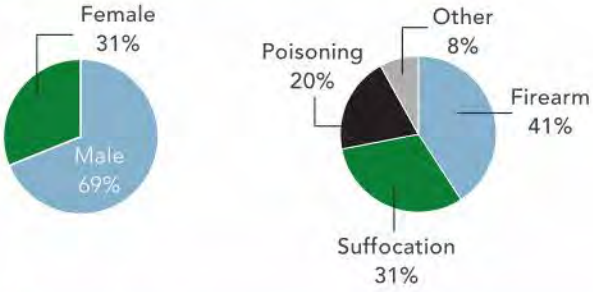
Differences exist among those with and without mental health conditions.

People without known mental health conditions were more likely to be male and to die by firearm.

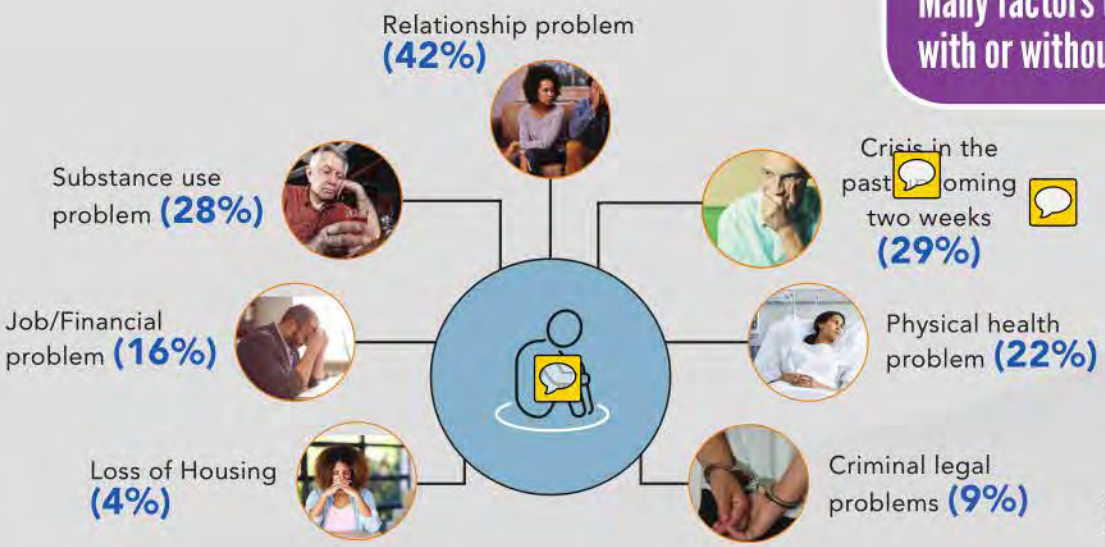
No known mental health conditions



Known mental health conditions



Many factors contribute to suicide among those with or without mental health conditions.



SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

WHAT CAN WE DO TO PREVENT SUICIDE?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices
https://go.usa.gov/xQBGc

Preventing Suicide Involves Everyone in the Community

Provide Financial Support to Individuals in Need

States can help ease unemployment and housing stress by providing temporary help.

Strengthen Access to and Delivery of Care

Healthcare providers can treat patients by phone or online where services are not widely available.

Create Protective Environments

Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect People within their Communities

Communities can use programs and events to increase a sense of belonging.

Teach Coping and Problem-Solving Skills

Schools can teach students skills to manage challenges like relationship and school problems.

Prevent Future Risk

Media can describe helping resources and avoid headlines or details that increase risk.

Identify and Support People at Risk

Everyone can learn the signs of suicide, how to respond, and where to get help.

Healthcare providers can offer at-risk patients effective treatment options.

Know the Suicide WARNING SIGNS

- Feeling like a Burden
- Isolation
- Increased Anxiety
- Feeling Trapped or in Unbearable Pain
- Increased Substance Use
- Looking for a Way to Access Lethal Means
- Increased Anger or Rage
- Extreme Mood Swings
- Expressing Hopelessness
- Sleeping Too Little or Too Much
- Talking or Posting About Wanting to Die
- Making Plans for Suicide

5 STEPS TO HELP

- Ask
- Keep them Safe
- Be There
- Help them Connect
- Follow Up

Find out why this can save a life by visiting: http://www.bethe1to.com.

SOURCE: *bethe1to.com*

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking the problem to understand trends and the groups at greatest risk (for example, see www.cdc.gov/violenceprevention/nvdrs).
- Developing and evaluating suicide prevention strategies.
- Working with local, state, tribal, national, and other partners to provide guidance and distribute suicide prevention tools (for example, see https://go.usa.gov/xQBGc).

STATES AND COMMUNITIES CAN

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Connect people to others in their community so they don't feel alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

HEALTHCARE SYSTEMS CAN

- Provide high quality, ongoing care focused on patient safety and suicide prevention.
- Make sure affordable and effective mental and physical healthcare is available where people live.
- Train providers in adopting proven treatments for patients at risk of suicide.

EMPLOYERS CAN

- Promote employee health and well-being, support employees at risk, and have plans in place to respond to people showing warning signs.
- Encourage employees to seek help. Provide referrals to mental health, substance use disorder, legal, or financial counseling services as needed.

EVERYONE CAN

- Ask someone you are worried about if they're thinking about suicide.
- Keep them safe. Reduce access to lethal means for those at risk.
- Be there with them. Listen to what they need.
- Help them connect with ongoing support like the lifeline (800-273-8255).
- Follow up to see how they're doing.
- Find out why this can save a life by visiting: www.bethe1to.com/.

The media can avoid increasing risk (e.g., with dramatic headlines, and explicit details) and encourage people to seek help using recommendations available at:
www.ReportingOnSuicide.org

If you need help for yourself or someone else, please contact the
National Suicide Prevention Lifeline
Talk: **1-800-273-TALK (8255)**
Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: June 7, 2018

Page 1

June 2018

Suicide rising across the US
More than just a mental health condition

45K
Nearly 45,000 lives lost to suicide in 2016.

30%
Suicide rates went up more than 30% in half of states since 1999.

54%
More than half of people who died by suicide did not have a known mental health condition.

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as relationship problems or loss, substance use disorders, physical health problems, and job, money, legal, or housing stress. Government, public health, healthcare, business, education, media and community organizations working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

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- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
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- Hold activities that bring people together so that they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

Page 2

Problem: Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.

Increase 38-58%
Increase 32-37%
Increase 19-29%
Increase 6-18%
Decrease 1%
Source: CDC's National Vital Statistics System

Differences exist among those with and without mental health conditions. People without known mental health conditions were more likely to be male and to die by firearm.

PIE CHART
No known mental health conditions

Sex
Female 16%
Male 84%

Method
Other 8%
Poisoning 10%
Suffocation 27%
Firearm 55%

Known mental health conditions

Sex
Female 31%
Male 69%

Method
Other 8%
Poisoning 20%
Suffocation 31%
Firearm 41%

Many factors contribute to suicide among those with or without mental health conditions
GRAPHIC

Comment [PB(]: "or" or "and"
Many factors contribute to both groups, so I think this may be an "and"

Relationship problem (42%)
Substance use problem (28%)
Crisis in the past/upcoming two weeks (29%)
Criminal legal problems (9%)
Physical health problem (22%)
Loss of housing (4%)
Job/Financial problem (16%)

SOURCE: CDC's National Violent Death Reporting System, data from 27 states participating in 2015.

Page 3

What can we do to prevent suicide?

Preventing Suicide: A Technical Package of Policy, Programs, and Practices, go.usa.gov/xQBGc.

Preventing Suicide Involves Everyone in the Community

Provide Financial Support to Individuals in Need

- States can help ease unemployment and housing stress by providing temporary support.

Strengthen Access to and Delivery of Care

- Healthcare providers can treat patients by phone or online where services are not widely available.

Create Protective Environments

- Employers can apply policies that create a healthy environment and reduce stigma about seeking help.

Connect People within their Communities

- Communities can use programs and events to increase a sense of belonging.

Teach Coping and Problem-Solving Skills

- Schools can teach students skills to manage challenges like relationship and school problems.

Identify and Support People at Risk

- **Everyone** can learn the signs of suicide, how to respond, and where to access help.
- **Healthcare providers** can offer at-risk patients effective treatment options. .

Prevent Future Risk

- Media can describe helping resources and avoid headlines or detailst that increase risk.

Suicide WARNING SIGNS

Comment [PB(]: Aren't we using the HHS terminology – "Substance use disorder" I think "Substance Use Problem" will get flagged at HHS.

Comment [PB(]: How do you know if you are going to have a crisis in the upcoming 2 weeks? Didn't see this before but I'm not sure people will understand this bullet

Comment [PB(]: If keep current language, would consider rephrasing to "Crisis in past or upcoming 2 weeks"

Comment [PB(]: Recommend deleting this bubble and bullet. See comment under "Identify and Support People at Risk"

Comment [PB(]: This HCP bullet is saying the same thing as the HCP bullet under 'Strengthen Accessto and Delivery of care". Don't think we need both bullets. Recommend deleting ""Strengthen access to and Delivery of Care" bubble and bullet since it's redundant to this bullet and there was so much controvery over what is suicide care and what treatement are providers giving. Instead you can expand the HCP bullet here to say:

"Healthcare providers can offer at-risk patients effective treatment options in their office or by phone or online where services are not widely available.

Comment [PB(]: Important to Rich: Add the number "12" and change to

"Know the 12 Warning Signs of Suicide"

Increased Substance Use
Feeling Trapped or in Unbearable Pain
Increased Anger or Rage
Extreme Mood Swings
Talking or Posting About Wanting to Die
Expressing Hopelessness
Sleeping too little or too much
Making Plans for Suicide
Isolation
Increased Anxiety
Looking for a Way to Access Lethal Means
Feeling like a burden

SOURCE: www.bethe1to.com.

5 Steps to help

- **Ask**
- **Keep them safe**
- **Be there**
- **Help them connect**
- **Follow up**

Find out how this can save a life by visiting: http://www.bethe1to.com/

Source: www.bethe1to.com

Page 4

WHAT CAN BE DONE

The Federal government is

- Tracking the problem to describe trends, circumstances, and populations at greatest risk (for example see www.cdc.gov/violenceprevention/nvdrs/).
- Developing and evaluating suicide prevention strategies.
- Working with local, state, tribal, national, and other partners to provide guidance and distribute suicide prevention tools (for example, see **https://go.usa.gov/xQBGc**).

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Everyone can

- Ask someone you are worried about if they're thinking about suicide.
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- Be there with them. Listen to what they need.
- Help them connect with ongoing support like the Lifeline (800-273-8255).
- Follow up to see how they're doing.
- Find out how this can save a life by visiting: www.bethe1to.com.

The media can avoid increasing risk (e.g., don't use dramatic headlines, or explicit details) and encourage people to seek help using recommendations available at: **www.ReportingOnSuicide.org**

Comment [OSL(]: This section should match the same section on page 1.

If you need help for yourself or someone else, please contact the

National Suicide Prevention Lifeline

Talk: **1-800-273-TALK (8255)**

Chat: **www.suicidepreventionlifeline.org**

www.cdc.gov/vitalsigns/suicide

www.cdc.gov/mmwr

For more information, please contact Telephone: 1-800-CDC-INFO (232-4636) TTY: 1-888-232-6348 |
Web: www.cdc.gov
Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333

Publication date: June 1, 2018

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 6 Feb 2018 13:46:23 -0500
To: Mercy, James (CDC/ONDIEH/NCIPC)
Cc: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs

Yes – we are planning monthly meetings to keep them engaged and have commitments in writing.

From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: Tuesday, February 06, 2018 1:03 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: Vital Signs

Sounds great Erin, thanks for doing this call. Let's remember that when we engaged AA within the last 6 months or so around suicide prevention week (or maybe it was something else - I'm not clearly remembering what specifically it was) they didn't really include much of our work in their communications (e.g., no mention of the suicide TP). So even though they are nice on the phone I think we will need to persistently push them.

Jim

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Friday, February 2, 2018 2:31 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>
Cc: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Subject: Vital Signs

I wanted to let you know we had a great call this afternoon with Kim Torguson and Farah Kauffman at the Action Alliance to talk about the Vital Signs. They were very excited and appreciative that we gave them so much advance notice--they said they usually only get a couple days notice on partners releases. They are thrilled to work with us to help promote the Vital Signs and associated suicide prevention messages. Below are some ideas we are toying with:

- AA can promote via a collective statement from the AA Media Messaging Group
- AA can promote via the AA and SPRC (Bridgette Hausman) social media and listserves (to state grantees, academia, etc.)
- AA can promote with the Congressional Mental Health Caucus and Congressional Suicide Prevention Task Force
- AA will provide us with their press release boiler plate language regarding requesting media to use the recommendations for reporting on suicide
- CDC and AA can co-host a twitter chat under Deb H handle and incorporate the technical package, transforming communities, etc. This is an opportunity to reach another audience from our usual (since our Facebook is generally more successful then our twitter). *If everyone is supportive we can reach to OC to identify Deb's interest and potential days/times to work with AA to put it on the calendar.*

- Sara will put Jim on the agenda for the March 14 AA ExCom meeting to give an intro/update on the Vital Sign and potential opportunity for collaborative promotion with AA partners to specific target audiences particularly with the release's proximity to suicide prevention month
- Naturally, AA is interested in seeing an early embargoed copy

From: Trudeau, Aimee T. (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 09:57:46 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Oh, right. Sighhh – well good luck with those, I know they can be a pain!
Aimée

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 07, 2018 9:57 AM
To: Trudeau, Aimee T. (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

The hard part is yet to come with interviews and such!! Fingers crossed!

From: Trudeau, Aimee T. (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 9:50 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: FW: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Congrats Deb! I know you're so relieved to have this out and complete!
Aimée

From: Young, Joni (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 06, 2018 4:10 PM
To: CDC ONDIEH NCIPC DVP ALL <cipdvpall@cdc.gov>
Cc: Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Qualters, Judy (CDC/ONDIEH/NCIPC) <jxq1@cdc.gov>; Edwards, Peter (CDC/ONDIEH/NCIPC) <poe0@cdc.gov>; Ballesteros, Michael (Mick) (CDC/ONDIEH/NCIPC) <zzb0@cdc.gov>; Kresnow-Sedacca, Marcie-jo (CDC/ONDIEH/NCIPC) <mjk1@cdc.gov>
Subject: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Good Afternoon,

We are pleased to share that the June CDC Vital Signs will focus on suicide prevention. Vital Signs is a CDC report that is part of the CDC journal Morbidity and Mortality Weekly Report (MMWR). The report provides the latest data and information on key health indicators, and what can be done to drive down these health threats. In addition to the MMWR article, the release includes a fact sheet and website, a press release and media telebriefing, social media tools, and a Town Hall teleconference with states. The report is being released tomorrow, **June 7th at 1pm** and you can view it here: https://www.cdc.gov/vitalsigns/index.html. The Vital Signs team – led by Deb Stone – examined state-level trends in suicide rates from 1999-2016. In addition, they looked at the circumstances of suicide among people with and without known mental health conditions using NVDRS data. The report highlights the suicide prevention technical package and strategies for comprehensive suicide prevention. The end result reflects the great collaborative work between DVP SMEs, Policy, Communication, ADS, and DARPI (Scott Kegler).

We are proud to have this work reported as a Vital Signs. A lot of time and effort has gone into preparing this package of Vital Signs materials and we are extremely appreciative of the contribution from all of the staff involved!

Thank you,
Joni

Joni C. Young
Deputy Director
Division of Violence Prevention
NCIPC, CDC
Office: 770-488-1378
Blackberry: 404-247-0949
JYoung@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 6 Jun 2018 22:15:48 +0000
To: Massetti, Greta M. (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Thanks, Greta! What an experience so far!
Deb

From: Massetti, Greta M. (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 5:23 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: Fwd: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

This is so exciting! Congratulations!!
Greta Massetti, Ph.D.
Centers for Disease Control and Prevention
(770) 488-3943
gmassetti@cdc.gov
https://www.cdc.gov/violenceprevention/childabuseandneglect/vacs/
---------- Forwarded message ----------
From: "**Young, Joni (CDC/ONDIEH/NCIPC)**" <gzc8@cdc.gov>
Date: Wed, Jun 6, 2018 at 4:09 PM -0400
Subject: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
To: "CDC ONDIEH NCIPC DVP ALL" <cipdvpall@cdc.gov>
Cc: "Kegler, Scott R. (CDC/ONDIEH/NCIPC)" <snk6@cdc.gov>, "Qualters, Judy (CDC/ONDIEH/NCIPC)" <jxq1@cdc.gov>, "Edwards, Peter (CDC/ONDIEH/NCIPC)" <poe0@cdc.gov>, "Ballesteros, Michael (Mick) (CDC/ONDIEH/NCIPC)" <zzb0@cdc.gov>, "Kresnow-Sedacca, Marcie-jo (CDC/ONDIEH/NCIPC)" <mjk1@cdc.gov>

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Office: 770-488-1378
Blackberry: 404-247-0949
JYoung@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 6 Jun 2018 21:16:17 +0000
To: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Thanks, Jeff! Don't jinx me!
Deb

From: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 4:15 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: FW: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Deb – You are awesome!!! Jeff

From: Young, Joni (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 4:10 PM
To: CDC ONDIEH NCIPC DVP ALL <cipdvpall@cdc.gov>
Cc: Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Qualters, Judy (CDC/ONDIEH/NCIPC) <jxq1@cdc.gov>; Edwards, Peter (CDC/ONDIEH/NCIPC) <poe0@cdc.gov>; Ballesteros, Michael (Mick) (CDC/ONDIEH/NCIPC) <zzb0@cdc.gov>; Kresnow-Sedacca, Marcie-jo (CDC/ONDIEH/NCIPC) <mjk1@cdc.gov>
Subject: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Good Afternoon,

We are pleased to share that the June CDC Vital Signs will focus on suicide prevention. Vital Signs is a CDC report that is part of the CDC journal Morbidity and Mortality Weekly Report (MMWR). The report provides the latest data and information on key health indicators, and what can be done to drive down these health threats. In addition to the MMWR article, the release includes a fact sheet and website, a press release and media telebriefing, social media tools, and a Town Hall teleconference with states. The report is being released tomorrow, **June 7th at 1pm** and you can view it here: https://www.cdc.gov/vitalsigns/index.html. The Vital Signs team – led by Deb Stone – examined state-level trends in suicide rates from 1999-2016. In addition, they looked at the circumstances of suicide among people with and without known mental health conditions using NVDRS data. The report highlights the suicide prevention technical package and strategies for comprehensive suicide prevention. The end result reflects the great collaborative work between DVP SMEs, Policy, Communication, ADS, and DARPI (Scott Kegler).

We are proud to have this work reported as a Vital Signs. A lot of time and effort has gone into preparing this package of Vital Signs materials and we are extremely appreciative of the contribution from all of the staff involved!

Thank you,
Joni

Joni C. Young
Deputy Director
Division of Violence Prevention
NCIPC, CDC
Office: 770-488-1378
Blackberry: 404-247-0949
JYoung@cdc.gov

From: Matjasko, Jennifer (CDC/ONDIEH/NCIPC)
Sent: 6 Jun 2018 16:57:34 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

(b)(6)

Yay, [redacted]! That is something to look forward to. Hang in there, it will be here before you know it!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 4:56 PM
To: Matjasko, Jennifer (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

(b)(6)

Thanks, Jen! I appreciate your email. [redacted] as it turns out! ☺ I need it now but will wait a few weeks!
Deb

From: Matjasko, Jennifer (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 4:54 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: FW: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

(b)(6)

Hi Deb, I wanted to congratulate you in advance on this huge accomplishment. I am looking forward to the release. I know how much effort goes into these Vital Signs and I hope you find the end result rewarding. And, I hope you reward yourself with a [redacted] ☺

From: Young, Joni (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 4:10 PM
To: CDC ONDIEH NCIPC DVP ALL <cipdvpall@cdc.gov>
Cc: Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Qualters, Judy (CDC/ONDIEH/NCIPC) <jxq1@cdc.gov>; Edwards, Peter (CDC/ONDIEH/NCIPC) <poe0@cdc.gov>; Ballesteros, Michael (Mick) (CDC/ONDIEH/NCIPC) <zzb0@cdc.gov>; Kresnow-Sedacca, Marcie-jo (CDC/ONDIEH/NCIPC) <mjk1@cdc.gov>
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Joni
Joni C. Young
Deputy Director
Division of Violence Prevention
NCIPC, CDC
Office: 770-488-1378
Blackberry: 404-247-0949
JYoung@cdc.gov

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 6 Jun 2018 20:16:22 +0000
To: Mercado-Crespo, Melissa (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Thanks!

From: Mercado-Crespo, Melissa (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 4:12 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

YEAY!!!!!! ☺ You're a rock star!

From: Young, Joni (CDC/ONDIEH/NCIPC)
Sent: Wednesday, June 6, 2018 4:10 PM
To: CDC ONDIEH NCIPC DVP ALL <cipdvpall@cdc.gov>
Cc: Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Qualters, Judy (CDC/ONDIEH/NCIPC) <jxq1@cdc.gov>; Edwards, Peter (CDC/ONDIEH/NCIPC) <poe0@cdc.gov>; Ballesteros, Michael (Mick) (CDC/ONDIEH/NCIPC) <zzb0@cdc.gov>; Kresnow-Sedacca, Marcie-jo (CDC/ONDIEH/NCIPC) <mjk1@cdc.gov>
Subject: Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

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Joni
Joni C. Young
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NCIPC, CDC
Office: 770-488-1378
Blackberry: 404-247-0949
JYoung@cdc.gov

From: Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
Sent: 10 May 2018 10:16:42 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC)
Subject: RE: VS Pre-brief

Hi Tom and Erin,

We usually refer people to our Uniform Definitions Document for this information (https://www.cdc.gov/violenceprevention/pdf/self-directed-violence-a.pdf). This document provides suggested terminology, definitions, and unacceptable terms.

Thanks,

Asha

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 10, 2018 9:28 AM
To: Black, Erin (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC)
Subject: RE: VS Pre-brief

Hi Erin,

Thank you. This all sounds good. The only change I would suggest is that we work to integrate the recommended terminology in a box in the telebriefing script as that evolves rather than send a separate email about this.

Alex, Kristin, Asha, do you have a list already (e.g., don't use "successful attempt" or "commit")?

-Tom

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Thursday, May 10, 2018 12:02 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Ivey-Stephenson, Asha Z.

(CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Subject: RE: VS Pre-brief

Tom – Crystal and I can work together on the following, if helpful:

- Send terminology guidance to SG – if you can send to us
- Ask Medscape about CME training credit
- Review the tele-briefing script to ensure the proposed headlines are the most appropriate
- Identify individuals in the states to connect reporters to (re states examples)
- Cross-walk tele-brief script with the media recommendations

---

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 9, 2018 11:04 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Subject: RE: VS Pre-brief

Hi Erin,

This is great – thank you so much for taking notes and creating the helpful matrix! We started dividing up the list of activities. I will spend more time in the morning making sure that everything is covered.

I really appreciated everyone participating in the briefing. I was very pleased with the outcome. I think we can address all of the concerns raised and will have a stronger product as a result. I also think that Dr. Schuchat is going to do a great job representing us.

I want to share with everyone that the communication team and I had a good call today with the VS team and the graphics artist and came up with some alternative ways to present the material on page 3 of the FS which should allow us to include the 5 steps in the bethe1to.com movement.

If you have other changes to the FS or press release beyond those that Erin summarized and page 3 please send them to me and Crystal tomorrow so that we can incorporate them in the revision that is due back to the VS team by cob. I have the feedback that Scott and Asha provided already.

Thank you,

-Tom

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Wednesday, May 9, 2018 2:42 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Kegler, Scott

R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>

Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>

Subject: VS Pre-brief

Congrats all on a great pre-brief! Anne (and Rich) even complimented us on how few changes 'compared to other pre-briefs' they had for us! Attached are my messy in-depth notes (transcripty) and also a chart of just the requested changes – please make sure I captured it as you all heard it! Also, below are some of the action items and next steps (in addition to making all the attached requested changes)!

Action Items:

- Confirm with Rich if Deb will be the SME poc at the tele-briefing
- Promote VS again after NCHS data brief
- Rich to confirm when NCHS is releasing the Data Brief
- Send terminology guidance to SG
- Ask Medscape about CME training credit
- Review the tele-briefing script to ensure the proposed headlines are the most appropriate
- Identify individuals in the states to connect reports to (re states examples)
- Crystal to cross-walk tele-brief script with the media recommendations
- Call with graphic designers to make "Be the One" bullets fit
- Propose to Schuchat's special assistant that suicide rates by age be added to the text in the MMWR intro
- Kristen to work on updating the Q&As – Tom to send the description of the increase
- Scott to draft Q&A on the big numbers and not jumping around

Next Steps:

- Revised Factsheet and Press release due **May 10** to graphic designer (have call prior)
- Changes to the tele-brief script and other comms materials by **May 14**
- Package goes to ASPA by **May 18**

-----Original Appointment-----

From: Schuchat, Anne MD (CDC/OD)

Sent: Friday, April 13, 2018 1:56 PM

To: Schuchat, Anne MD (CDC/OD); Peaker, Brandy (CDC/OPHSS/CSELS/DPHID); Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID); Sokler, Lynn (CDC/OD/OADC); Omisore, Shannon L. (CDC/OD/OADC); Sorrells, Marjorie J. (CDC/OD/OCS); Simon, Thomas (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Bruce, Crystal (CDC/OPHPR/OD); Black, Erin (CDC/ONDIEH/NCIPC); Dauphin, Leslie (CDC/OD/OADLSS); Daniel, Katherine Lyon (CDC/OD/OADC); Bonds, Michelle E. (CDC/OD/OADC); Harben, Kathy (CDC/OD/OADC); Gaines-McCollom, Molly (CDC/OPHPR/DEO); Grusich, Katherina (Kate) (CDC/OD/OADC); DeNoon, Daniel (CDC/OD/OADC) (CTR); Howe, Kristin (CDC/OCOO/OCIO/ITSO) (CTR); Corley, Ronald D. (CDC/OCOO/OCIO/ITSO) (CTR); Kegler, Scott R. (CDC/ONDIEH/NCIPC)

Subject: 1:00pm - 1:45pm Vital Signs Pre-brief: Suicide Prevention

When: Tuesday, May 8, 2018 1:00 PM-2:00 PM (UTC-05:00) Eastern Time (US & Canada).

Where: 12th Floor -- OD Suite, Conference Room 12302 (Conference Bridge: 877-985-4535, PC94833493
)

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 4 Jan 2018 14:06:33 -0500
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Daniel, Valerie M. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: RE: VS Release Date for Suicide Prevention
Attachments: June 2018 Deliverables calendar_21Nov2017.xlsx

Yes Molly is the comms lead, but Malia and Crystal are also working on the partnership outreach piece so please invite them as well.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, January 04, 2018 1:54 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC)
Subject: RE: VS Release Date for Suicide Prevention

Hi Erin,
I think you and Molly agreed that she would be the comm lead on the VS. Is that still the case? Do you want Deb to invite her?
-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, January 4, 2018 1:27 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Subject: RE: VS Release Date for Suicide Prevention

Hi Tom,
Thanks for keeping this conversation going. I really appreciate it. Yes, I think it would be fine to add the topic to our meeting on Tuesday (12-1), assuming Erin/designee is free. Does 15 mins seem reasonable? We could do it at the start or at the end of the meeting. Erin, let me know what you think and I'll send the invite.
Thanks!
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, January 4, 2018 12:50 PM
To: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: VS Release Date for Suicide Prevention

Hi Erin,
Attached is the deliverables timeline for the suicide VS. It will be very helpful to have the comm/policy side make assignments for each task. I think it would also be good for us to have a discussion before the suicide briefing about the options for promoting the vital signs. Deb, is there time to add this topic to the agenda for the upcoming VS meeting or should we set up a separate discussion?
Tom

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Thursday, January 4, 2018 11:48 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: VS Release Date for Suicide Prevention

Hey Tom – I know the dates will basically be pretty similar but has someone already started to update the timeline attachment to reflect our vital signs? We were going to do that on the comms/policy side

and assign a coms/policy poc for each task but wanted to see if there is an updated version already. Sorry if I missed it an you already sent it out.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Sunday, August 27, 2017 3:40 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>
Subject: FW: VS Release Date for Suicide Prevention

Hi everyone,

I heard back from Rich Schieber about our proposed Vital Signs on suicide. Here are the key issues:

- Based on our plan to have the MMWR ready for clearance by the end of February and to allow 5 weeks for NCIPC clearance, Rich suggests that we take the June 5, 2018 release date. The attached excel spreadsheet is an example of all the tasks related to a Vital Signs release and where they fall relative to the release date. Erin and Marie, I am sharing this with you as well as the writing team because there are a lot of communication-related deliverables for a Vital Signs (e.g., fact sheet, graphics, podcast, social media messages, press release, etc.) that the writing team and communication team will need to collaborate on and I want to make sure that a June 5 release can work for you too. We will need to make sure that we have coverage for media interviews. Deb, will you be available that week? Erin and Deb, please confirm that you are ok committing to June 5th. I need to let Rich know that we want that spot. I think we have a good head start on the plan for the MMWR and that we can work together to stay ahead of the timelines that they will have for us, but If anyone has any concerns please let us know by 8/30. Jim is also checking with Deb Houry to make sure she is ok with the June release date.
- Rich has also provided the attached example of shorter version of the OD planning document. We will need to get this approved through Jim and Deb before sending it to him. He would like this by the end of September. We can pretty easily adapt the content from the template that we had been working on together.

It looks like this could be a reality!

-Tom

June 5, 2018
Suicide

Abbreviated Timelines of Deliverables, 11/21/2017

Step	Deliverable	Begin at 08:00 A.M.	End by COB	Workdays	Deliver to	Comments
Analysis, Direction-setting, and MMWR Prep						
1	(1) DIRECTION AND ANALYSIS: Initial Meeting		TBD			
2	OD Planning Document/SOHCO/One Thing		DONE		RS, LS	
3	CDC/OD review of ODPD/SOHCO/One Thing		DONE			
4	Program (PGM) respond in writing to questions from CDC/OD		DONE		RS	
5	(2) MMWR: MMWR draft(non-cleared)written and sent to VS team to help guide FS development during the RT discussion only		2-Apr		RS	
6	Pre-submission CIO-cleared MMWR due to VS team		10-Apr			
7	CDC/OD(Dir, Principal Depuy Dir, OADS, OADC); CSELS (Rasmussen, Kent)review pre-submission CIO cleared and cross-cleared MMWR	11-Apr	16-Apr	4	RS	MMWR and FS will be sent to CDC/OD at the same time.
8	PGM revises, cross-clears and submits MMWR to Editors	17-Apr	25-Apr	7	MMWR Submission System, RS, LS	Max 1800 word text 250 word abstract 15 references Submit to MMWR by noon Please send VS team a comment/response matrix on how you addressed comments from Drs. Schuchat, Mac Kenzie, and Lyon-Daniel. Matrix only needed for comments from these 3 reviewers
9	MMWR edited and produced	26-Apr	9-May	10	MMWR Editors and Reviewers, PGM, RS	
10	SCIENCE CLIPS: PGM provides citations for Science Clips		21-May		RS	
11	Rich reviews citations and sends to OD/OADS and CDC librarian		22-May		Bill Thomas John Iskander Gail Bang	
Fact Sheet (Word and Graphics Versions)						
12	(3) FACT SHEET: Send FS (non-cleared) in Word (W) format to VS team		2-Apr		LS, RS	
13	Roundtable	3-April 1:30-4:30			LS, RS	
14	CIO-cleared post-RT FS(W) due to VS team	4-Apr	10-Apr	5	LS, RS	
15	CDC/OD (Dir, Principal Depuy Dir, OADS, OADC,PARP, PPEO); CSELS (Rasmussen, Kent, Royster, Martin); CDCW review CIO-cleared FS(W)	11-Apr	16-Apr	4		

16	**Pgm revises FS(W) from CDC/OD, CSELS, CDCW comments and submits revised FS(W) to VS team**	17-Apr	25-Apr	7	RS,LS	Please send VS team a comment/response matrix on how you addressed comments from Drs. Schuchat, Mac Kenzie, and Lyon-Daniel. Matrix only needed for comments from these 3 reviewers
17	**Complete internal graphic development**	26-Apr	4-May	7	LS	
18	**CDC/OD (Principal Depuy Dir, OADS, OADC); CSELS (Kent); CDCW review full-color FS(G)**	4-May	Pre-brief with Principal Deputy Director, ADS, ADC (week of 5-Feb)		RS, LS	Principal Deputy Director, ADS, ADC will provide comments on FS, PR, telebriefing script,Q&A at the pre-brief Kent, CDCW will receive courtesy copies
19	**Work days: Final edits to FS(G)**	Pre-brief with Principal Deputy Director, ADS, ADC	17-May			
20	**HHS/ASPA review and clear full-color FS(G)**	18-May	24-May	5	LS to NMB to HHS/ASPA	Send FS with Press Release through NMB
21	**CDC Locks down full-color graphic FS(G)**		24-May		LS	at 5:00pm
22	**CDC final publication preparation (English and Spanish)**	25-May	4-Jun	6	LS	LS to send English FS to Shannon Omisore for Spanish translation Holiday 28-May
Other Materials Produced						
23	**Medical Outreach Program call**		while FS is being reviewed by OD		Brandy Peaker	Program to discuss with VS potential outreach strategies for clinicians
24	**(5) TOWN HALL MEETING PREP: PGM finds 2 local demo pgms for Town Hall Mtg**		8-May		OSTLTS: Chelsea Payne, Tonya Joyner	PGM works independently with OSTLTS for this
25	**(6) PRESS RELEASE (PR) and ONE GRAPHIC: Lynn receives draft, edits it, and sends revision back to PGM**		27-Apr		PGM	
26	**Pgm revises PR**	30-Apr	4-May	5	LS, DNEM	
27	**OADC reviews PR**	7-May	11-May	5		
28	**Pgm revises PR from OADC review**	14-May	17-May	4		
29	**HHS/ASPA receives and clears PR**	18-May	24-May	5	LS	
30	**PGM OKs ASPA changes to social media materials and PR**		25-May	1	LS	
31	**Lynn, graphics, and PGM to work on "one graphic" to go with PR**	18-May	24-May	5	LS	
32	**(7) DEAR COLLEAGUE LETTER: PGM writes/clears/submits**		27-Apr		LS	CD sends to MLS for Spanish translation
33	**(8) TELEBRIEFING SCRIPT and Q&A PGM writes/clears/submits**		27-Apr		LS	SO sends English script to Belsie Gonzalez for Spanish talking points

34	**(9) CRITICAL CONTACTS and EMAIL PGM writes/clears/submits**		27-Apr		RS/LS	
Final Activities						
35	**(12) SOCIAL and ELECTRONIC MEDIA: Meet with Kamelya Hinson and PGM to go over Social and Electronic Media**		24-Apr		LS, DNEM,PGM	6 weeks prior to release; OADC to provide PGM with a social media template
36	**PGM to provide content to Kamelya Hinson; PGM works with LaKia Bryant to provide content on Digital Press Kit**		8-May		PGM, Kamelya Hinson, Arezoo Risman	4 weeks prior to release; PGM to work directly with OADC on social and electronic media. SO sends to MLS for Spanish translation
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38	**Rich creates CDC Announcement**		29-May		Rhonda Smith	CDC Announcement released at 2pm on 6-Mar
39	**(14) PRE-BRIEFING: LS sends latest MMWR proof, FS/Graphics version, PR, Telebriefing Script, Q&A, Critical Contacts List and draft email**		4-May		LS	PGM to send all requested material by 10AM
40	**Pre-brief with Principal Deputy Director, ADS, ADC**		week of 7-May		In-person (unless traveling)	Bldg 21, 12th floor DIV: Leadership, Comm, Policy, Science SMEs Call in number provided
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46	**External (cont)--PGM and OSTLTS notify all other partners of impending release**		5-Jun			BRANCH: SME, Chief, Comm, Policy; Embargo in place until 1 pm
47	**(16) RELEASE Press receives materials under embargo**		5-Jun		RS, LS, DNEM	Embargo in place until 1pm
48	**CDC Director conducts telebriefing Materials released to public at 1pm**		5-Jun		TRF, LS, RS, OADC, PGM	Immediate Pre-brief 11:40; Telebrief at NOON, Dir Conf Rm, Bldg 21, 12th floor DIV: Director, Comm, Policy BRANCH: Chief, SME, Comm, Policy
49	**(17) MEDIA METRICS COLLECTED 24-hour media report due**		6-Jun		LS, DNEM	
50	**30-day Media report due**		30 days after release		LS, DNEM	
51	**(18) OSTLTS TOWN HALL PGM participates**		12-Jun		OSTLTS	SME presents overview

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: 4 Jan 2018 12:49:37 -0500
To: Black, Erin (CDC/ONDIEH/NCIPC)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: VS Release Date for Suicide Prevention
Attachments: June 2018 Deliverables calendar_21Nov2017.xlsx

Hi Erin,
Attached is the deliverables timeline for the suicide VS. It will be very helpful to have the comm/policy side make assignments for each task. I think it would also be good for us to have a discussion before the suicide briefing about the options for promoting the vital signs. Deb, is there time to add this topic to the agenda for the upcoming VS meeting or should we set up a separate discussion?
Tom

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: Thursday, January 4, 2018 11:48 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: VS Release Date for Suicide Prevention

Hey Tom – I know the dates will basically be pretty similar but has someone already started to update the timeline attachment to reflect our vital signs? We were going to do that on the comms/policy side and assign a coms/policy poc for each task but wanted to see if there is an updated version already. Sorry if I missed it an you already sent it out.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Sunday, August 27, 2017 3:40 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>
Cc: Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>
Subject: FW: VS Release Date for Suicide Prevention

Hi everyone,
I heard back from Rich Schieber about our proposed Vital Signs on suicide. Here are the key issues:

- Based on our plan to have the MMWR ready for clearance by the end of February and to allow 5 weeks for NCIPC clearance, Rich suggests that we take the June 5, 2018 release date. The attached excel spreadsheet is an example of all the tasks related to a Vital Signs release and where they fall relative to the release date. Erin and Marie, I am sharing this with you as well as the writing team because there are a lot of communication-related deliverables for a Vital Signs (e.g., fact sheet, graphics, podcast, social media messages, press release, etc.) that the writing team and communication team will need to collaborate on and I want to make sure that a June 5 release can work for you too. We will need to make sure that we have coverage for media interviews. Deb, will you be available that week? Erin and Deb, please confirm that you are ok committing to June 5th. I need to let Rich know that we want that spot. I think we have a good head start on the plan for the MMWR and that we can work together to stay ahead of the timelines that they will have for us, but If anyone has any concerns please let us know by 8/30. Jim is also checking with Deb Houry to make sure she is ok with the June release date.

- Rich has also provided the attached example of shorter version of the OD planning document. We will need to get this approved through Jim and Deb before sending it to him. He would like this by the end of September. We can pretty easily adapt the content from the template that we had been working on together.

It looks like this could be a reality!

-Tom

June 5, 2018
Suicide

Abbreviated Timelines of Deliverables, 11/21/2017

Step	Deliverable	Begin at 08:00 A.M.	End by COB	Workdays	Deliver to	Comments
Analysis, Direction-setting, and MMWR Prep						
1	(1) DIRECTION AND ANALYSIS: Initial Meeting		TBD			
2	OD Planning Document/SOHCO/One Thing		DONE		RS, LS	
3	CDC/OD review of ODPD/SOHCO/One Thing		DONE			
4	Program (PGM) respond in writing to questions from CDC/OD		DONE		RS	
5	(2) MMWR: MMWR draft(non-cleared)written and sent to VS team to help guide FS development during the RT discussion only		2-Apr		RS	
6	Pre-submission CIO-cleared MMWR due to VS team		10-Apr			
7	CDC/OD(Dir, Principal Depuy Dir, OADS, OADC); CSELS (Rasmussen, Kent)review pre-submission CIO cleared and cross-cleared MMWR	11-Apr	16-Apr	4	RS	MMWR and FS will be sent to CDC/OD at the same time.
8	PGM revises, cross-clears and submits MMWR to Editors	17-Apr	25-Apr	7	MMWR Submission System, RS, LS	Max 1800 word text 250 word abstract 15 references Submit to MMWR by noon Please send VS team a comment/response matrix on how you addressed comments from Drs. Schuchat, Mac Kenzie, and Lyon-Daniel. Matrix only needed for comments from these 3 reviewers
9	MMWR edited and produced	26-Apr	9-May	10	MMWR Editors and Reviewers, PGM, RS	
10	SCIENCE CLIPS: PGM provides citations for Science Clips		21-May		RS	
11	Rich reviews citations and sends to OD/OADS and CDC librarian		22-May		Bill Thomas John Iskander Gail Bang	
Fact Sheet (Word and Graphics Versions)						
12	(3) FACT SHEET: Send FS (non-cleared) in Word (W) format to VS team		2-Apr		LS, RS	
13	Roundtable	3-April 1:30-4:30			LS, RS	
14	CIO-cleared post-RT FS(W) due to VS team	4-Apr	10-Apr	5	LS, RS	
15	CDC/OD (Dir, Principal Depuy Dir, OADS, OADC,PARP, PPEO); CSELS (Rasmussen, Kent, Royster, Martin); CDCW review CIO-cleared FS(W)	11-Apr	16-Apr	4		

16	**Pgm revises FS(W) from CDC/OD, CSELS, CDCW comments and submits revised FS(W) to VS team**	17-Apr	25-Apr	7	RS,LS	Please send VS team a comment/response matrix on how you addressed comments from Drs. Schuchat, Mac Kenzie, and Lyon-Daniel. Matrix only needed for comments from these 3 reviewers
17	**Complete internal graphic development**	26-Apr	4-May	7	LS	
18	**CDC/OD (Principal Depuy Dir, OADS, OADC); CSELS (Kent); CDCW review full-color FS(G)**	4-May	Pre-brief with Principal Deputy Director, ADS, ADC (week of 5-Feb)		RS, LS	Principal Deputy Director, ADS, ADC will provide comments on FS, PR, telebriefing script,Q&A at the pre-brief Kent, CDCW will receive courtesy copies
19	**Work days: Final edits to FS(G)**	Pre-brief with Principal Deputy Director, ADS, ADC	17-May			
20	**HHS/ASPA review and clear full-color FS(G)**	18-May	24-May	5	LS to NMB to HHS/ASPA	Send FS with Press Release through NMB
21	**CDC Locks down full-color graphic FS(G)**		24-May		LS	at 5:00pm
22	**CDC final publication preparation (English and Spanish)**	25-May	4-Jun	6	LS	LS to send English FS to Shannon Omisore for Spanish translation Holiday 28-May
Other Materials Produced						
23	**Medical Outreach Program call**		while FS is being reviewed by OD		Brandy Peaker	Program to discuss with VS potential outreach strategies for clinicians
24	**(5) TOWN HALL MEETING PREP: PGM finds 2 local demo pgms for Town Hall Mtg**		8-May		OSTLTS: Chelsea Payne, Tonya Joyner	PGM works independently with OSTLTS for this
25	**(6) PRESS RELEASE (PR) and ONE GRAPHIC: Lynn receives draft, edits it, and sends revision back to PGM**		27-Apr		PGM	
26	**Pgm revises PR**	30-Apr	4-May	5	LS, DNEM	
27	**OADC reviews PR**	7-May	11-May	5		
28	**Pgm revises PR from OADC review**	14-May	17-May	4		
29	**HHS/ASPA receives and clears PR**	18-May	24-May	5	LS	
30	**PGM OKs ASPA changes to social media materials and PR**		25-May	1	LS	
31	**Lynn, graphics, and PGM to work on "one graphic" to go with PR**	18-May	24-May	5	LS	
32	**(7) DEAR COLLEAGUE LETTER: PGM writes/clears/submits**		27-Apr		LS	CD sends to MLS for Spanish translation
33	**(8) TELEBRIEFING SCRIPT and Q&A PGM writes/clears/submits**		27-Apr		LS	SO sends English script to Belsie Gonzalez for Spanish talking points

34	**(9) CRITICAL CONTACTS and EMAIL PGM writes/clears/submits**		27-Apr		RS/LS	
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From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 8 Jun 2018 14:05:45 +0000
To: Ballman, Marie R. (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Subject: RE: VS release

Thank you, I hadn't seen!
Deb

From: Ballman, Marie R. (CDC/ONDIEH/NCIPC)
Sent: Friday, June 8, 2018 9:23 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Subject: RE: VS release
Congrat's again on the release yesterday!
Sorry if you all get the CDC's Did you know? Emails.
But in cause you don't, ours is attached.
Happy Friday,
Marie

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 2:06 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <ivm9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
Subject: VS release
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I wanted to let you know that many stories are already published. I'm sure we'll have a summary later but I encourage you to do a Google news search on "CDC" and "suicide" and you can get a sense. Many are talking about the need to broaden suicide prevention efforts and they are including a link to the technical package and the Lifeline.
It is very encouraging. More to come.
-Tom

From: Ballman, Marie R. (CDC/ONDIEH/NCIPC)
Sent: 8 Jun 2018 09:23:11 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Subject: RE: VS release
Attachments: Did You Know_ _ Suicide—more than a mental health concern.msg

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Sent: Thursday, June 7, 2018 2:06 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
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It is very encouraging. More to come.
-Tom

From: Centers for Disease Control and Prevention (CDC)
Sent: 8 Jun 2018 07:03:32 -0500
To: Ballman, Marie R. (CDC/ONDIEH/NCIPC)
Subject: Did You Know? | Suicide—more than a mental health concern

Did You Know?

June 8, 2018

According to this month's *Vital Signs*—

- Nearly 45,000 lives were lost to suicide in 2016, with rates increasing more than 30% in half of the states since 1999.
- More than half of people who die by suicide had no known mental health condition at the time of death.
- Health departments can work with communities to put in place a comprehensive suicide prevention program using CDC's *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*.



Interested in learning more? Join us for a *Vital Signs* Town Hall Teleconference on **Tuesday, June 12, at 2–3 pm (EDT).**

About *Did You Know?*
Did You Know? is a weekly feature from CDC's Office for State, Tribal, Local and Territorial Support to inform your prevention activities. We invite you to read, share, and take action!

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From: Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Sent: 8 Jun 2018 08:05:24 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Young, Joni (CDC/ONDIEH/NCIPC);Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Cc: Ferdon, Corinne (CDC/ONDIEH/NCIPC);Basile, Kathleen (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Payne, Gayle H. (CDC/ONDIEH/NCIPC);Massetti, Greta M. (CDC/ONDIEH/NCIPC)
Subject: RE: VS release

All - I concur with all of the kudos and congratulations. This work is so incredibly important as people are now beginning to realize the full extent and impact of this public health emergency on our families, friends, neighbors, etc.
The Vital Signs is an optimal mechanism to clearly convey our message and be a catalyst for change in the public health and healthcare systems, with (hopefully) increased resources for prevention and treatment.
It is such an honor to be a part of a Division whose mission is to prevent all forms of violence, everywhere and for everyone.
Jeff

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 4:58 PM
To: McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Young, Joni (CDC/ONDIEH/NCIPC) ; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Cc: Ferdon, Corinne (CDC/ONDIEH/NCIPC) ; Basile, Kathleen (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) ; Payne, Gayle H. (CDC/ONDIEH/NCIPC) ; Massetti, Greta M. (CDC/ONDIEH/NCIPC)
Subject: RE: VS release

Thanks, Kathleen and Greta,
Yes, this was a great team effort. Deb Stone did a fantastic job throughout the process! Alex, Kristin, Katie, Keming, Asha, Scott Kegler, Crystal, Erin, Malia, Molly, Marie and others from comm and policy were critical to the success and put in a lot of extra work. We'll send a more formal acknowledgement later to a wider audience. I just wanted to give you all a head's up about the response so far.
-Tom

From: McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 4:01 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Young, Joni (CDC/ONDIEH/NCIPC) <gzc8@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Cc: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Basile, Kathleen (CDC/ONDIEH/NCIPC) <ksb9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; Payne, Gayle H. (CDC/ONDIEH/NCIPC) <hfn5@cdc.gov>; Massetti, Greta M. (CDC/ONDIEH/NCIPC) <ghz6@cdc.gov>
Subject: RE: VS release

Huge congratulations to all involved! So glad that Surveillance Branch staff were part of the success of this Vital Signs.
Best,
Kathleen

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 3:43 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Young, Joni (CDC/ONDIEH/NCIPC) <gzc8@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Cc: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Basile, Kathleen (CDC/ONDIEH/NCIPC) <ksb9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC) <kzm2@cdc.gov>; Payne, Gayle H. (CDC/ONDIEH/NCIPC) <hfn5@cdc.gov>; Massetti, Greta M. (CDC/ONDIEH/NCIPC) <ghz6@cdc.gov>
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https://www.cnn.com/2018/06/07/health/suicide-report-cdc/index.html
https://www.nbcnews.com/health/health-news/suicide-rates-are-30-percent-1999-cdc-says-n880926
https://www.cbsnews.com/news/suicide-rates-rise-more-than-a-mental-health-issue-cdc-says/
https://www.indystar.com/story/news/2018/06/07/cdc-suicide-now-10th-leading-cause-death-cause-rise/681605002/
http://www.nydailynews.com/news/national/ny-news-us-suicide-rates-rising-20180607-story.html
https://abcnews.go.com/Politics/cdc-report-finds-rise-suicide-rates-states/story?id=55719214

Also, check out this Joint Statement from the Action Alliance supporting our findings:
http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Action%20Alliance_A%20Joint%20Statement_CDC%20Vital%20Signs%20June.pdf

Thanks go to Erin, Molly, Alex, and Kristin for representing us on the call with the Action Alliance that led to this!

It is very encouraging. More to come.

-Tom

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 15:28:51 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Subject: RE: VS release

Agree with Tom that the Telebriefing was a huge success! Big thanks to everyone that worked on the extensive Q&A document, almost every question asked was predicted in that document.

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 2:06 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
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From: Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 14:16:37 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Black, Erin (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Subject: RE: VS release

The statement is really great! So far, our social media activity is also quite positive. Go team!

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 2:16 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Subject: RE: VS release

One more and then I'll stop - Check out this Joint Statement from the Action Alliance supporting our findings:
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To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <ivm9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Jack, Shane P. Davis (CDC/ONDIEH/NCIPC) <gdo4@cdc.gov>
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Sent: 7 Jun 2018 14:13:21 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Jack, Shane P. Davis (CDC/ONDIEH/NCIPC)
Subject: RE: VS release

NPR did their own "map" graphics based on the stacks table: https://www.npr.org/sections/health-shots/2018/06/07/617897261/cdc-u-s-suicide-rates-have-climbed-dramatically.

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-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 21:51:44 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: VS release

Hi Tom,
Just did Huffington Post a little while ago. Will do BBC and ABC tomorrow.
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 5:07 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: VS release

Great – will you get to do them or are they going to Dr. S? I was hoping that you would get to do some more. You worked so hard to prep.
-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 4:31 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: VS release

That sounds good, Tom, thanks. We got some more requests for interviews, BBC, ABC news radio, and Huffington post.
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 4:27 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: VS release

Hi Deb,
You are welcome. I just wanted to send an update so that they know that it went well and that the coverage is generally what we had hoped for from the beginning.
We should talk tomorrow about a broader message that could go out acknowledging all the hard work from you and the entire group. I want to make sure not to miss anyone in that so will want to discuss it with you.
-Tom

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 3:54 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: VS release

Thank you for sending!!
Deb

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 3:43 PM
To: Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Young, Joni (CDC/ONDIEH/NCIPC) <gzc8@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Cc: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Basile, Kathleen (CDC/ONDIEH/NCIPC) <ksb9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC) <kzm2@cdc.gov>; Payne, Gayle H.

(CDC/ONDIEH/NCIPC) <hfn5@cdc.gov>; Massetti, Greta M. (CDC/ONDIEH/NCIPC) <ghz6@cdc.gov>
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http://www.nydailynews.com/news/national/ny-news-us-suicide-rates-rising-20180607-story.html
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From: Mercy, James (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 17:15:42 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Young, Joni (CDC/ONDIEH/NCIPC);Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Cc: Ferdon, Corinne (CDC/ONDIEH/NCIPC);Basile, Kathleen (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Herbst, Jeffrey (CDC/ONDIEH/NCIPC);McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC);Payne, Gayle H. (CDC/ONDIEH/NCIPC);Massetti, Greta M. (CDC/ONDIEH/NCIPC)
Subject: Re: VS release

I want to add my thanks and admiration to everyone else's kind words. You have made an unassailable case for investment in the prevention of suicide. This will, in and of itself, save lives. Thank you so much for time and commitment you contributed to this. You are amazing. I am so proud to have the privilege to work with you,

Sincerely,
Jim

From: Simon, Thomas (CDC/ONDIEH/NCIPC)
Date: June 7, 2018 at 3:43:22 PM EDT
To: Mercy, James (CDC/ONDIEH/NCIPC) , Young, Joni (CDC/ONDIEH/NCIPC) , Dahlberg, Linda L. (CDC/ONDIEH/NCIPC)
Cc: Ferdon, Corinne (CDC/ONDIEH/NCIPC) , Basile, Kathleen (CDC/ONDIEH/NCIPC) , Stone, Deborah (CDC/ONDIEH/NCIPC) , Black, Erin (CDC/ONDIEH/NCIPC) , Herbst, Jeffrey (CDC/ONDIEH/NCIPC) , McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC) , Payne, Gayle H. (CDC/ONDIEH/NCIPC) , Massetti, Greta M. (CDC/ONDIEH/NCIPC)
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https://www.nbcnews.com/health/health-news/suicide-rates-are-30-percent-1999-cdc-says-n880926
https://www.cbsnews.com/news/suicide-rates-rise-more-than-a-mental-health-issue-cdc-says/
https://www.indystar.com/story/news/2018/06/07/cdc-suicide-now-10th-leading-cause-death-cause-rise/681605002/
http://www.nydailynews.com/news/national/ny-news-us-suicide-rates-rising-20180607-story.html
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From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 7 Jun 2018 20:26:23 +0000
To: Holland, Kristin (CDC/ONDIEH/NCIPC)
Subject: RE: VS release

You're fine. When are we having happy hour?!

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 4:12 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: VS release

No, thank god!! Although, I'm shocked it didn't since I feel like a stuffed sausage in it! I gotta get back into my running routine!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 4:10 PM
To: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: VS release

Seriously, you need to be careful. You could have really gotten hurt! The dress didn't rip or anything did it?

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 4:09 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: VS release

I don't, but I did today to try to find something to wear. Unfortunately I chose shoes that put me at risk of falling in front of others! ;)

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 4:05 PM
To: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: VS release

I am. I'm ready to go home. I got up at like 5 this morning. You probably get up at that time every day!
D

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 4:04 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: VS release

Ha!!
You must be exhausted. I'm tired and I didn't even do anything!

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 4:03 PM
To: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: RE: VS release

That's ok. Tom is the man ;)
Literally and figuratively.
Deb

From: Holland, Kristin (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 4:01 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Subject: RE: VS release

Seriously??? How is it not abundantly clear that you led this?? So annoying. I'm sorry. ☹

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 3:59 PM
To: Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>
Subject: FW: VS release

Doh!

From: Massetti, Greta M. (CDC/ONDIEH/NCIPC)
Sent: Thursday, June 7, 2018 3:56 PM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Young, Joni (CDC/ONDIEH/NCIPC) <gzc8@cdc.gov>; Dahlberg, Linda L. (CDC/ONDIEH/NCIPC) <lld0@cdc.gov>
Cc: Ferdon, Corinne (CDC/ONDIEH/NCIPC) <djz4@cdc.gov>; Basile, Kathleen (CDC/ONDIEH/NCIPC) <ksb9@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>; McDavid Harrison, Kathleen (CDC/ONDIEH/NCIPC) <kzm2@cdc.gov>; Payne, Gayle H. (CDC/ONDIEH/NCIPC) <hfn5@cdc.gov>
Subject: RE: VS release

This is fantastic work, Tom. Congratulations to the whole DVP VS team on this important accomplishment, and to your leadership!

Greta Massetti, Ph.D.
Centers for Disease Control and Prevention
(770) 488-3943
gmassetti@cdc.gov
https://www.cdc.gov/violenceprevention/childabuseandneglect/vacs/

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http://thehill.com/policy/healthcare/391170-cdc-suicide-rates-increasing-in-almost-every-state
https://www.cnn.com/2018/06/07/health/suicide-report-cdc/index.html
https://www.nbcnews.com/health/health-news/suicide-rates-are-30-percent-1999-cdc-says-n880926
https://www.cbsnews.com/news/suicide-rates-rise-more-than-a-mental-health-issue-cdc-says/
https://www.indystar.com/story/news/2018/06/07/cdc-suicide-now-10th-leading-cause-death-cause-rise/681605002/
http://www.nydailynews.com/news/national/ny-news-us-suicide-rates-rising-20180607-story.html
https://abcnews.go.com/Politics/cdc-report-finds-rise-suicide-rates-states/story?id=55719214
Also, check out this Joint Statement from the Action Alliance supporting our findings:
http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Action%20Alliance_A%20Joint%20Statement_CDC%20Vital%20Signs%20June.pdf
Thanks go to Erin, Molly, Alex, and Kristin for representing us on the call with the Action Alliance that led to this!
It is very encouraging. More to come.
-Tom

From: /o=cdc/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=f43dd520d1854120aa942ac284dc7713-discoverysearchmailb
Sent: 9 Apr 2018 22:01:11 +0000
To: McKeon, Richard (SAMHSA/CMHS);Pearson, Jane L (NIH/NIMH) [E]
Subject: RE: **Request for your review: Suicide Vital Signs Fact Sheet

Hi Richard,
Thank you again for Here are two options for the revision to the intro. Do one of these work sound ok?
Despite the NSSP guidance, suicide prevention has largely focused on identifying and referring suicidal people to mental health treatment and preventing re-attempts (6). In addition to mental health problems (MHP) and prior attempts, other contributing circumstances to suicide include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, and poor coping and problem-solving skills (5).
Despite the NSSP guidance, suicide prevention largely focuses on identifying suicidal people, providing treatment for mental health problems (MHP) and preventing re-attempts (6). In addition to MHP and prior attempts, other contributing circumstances to suicide include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, and poor coping and problem-solving skills (5).
Deb

From: McKeon, Richard (SAMHSA/CMHS)
Sent: Friday, April 6, 2018 1:51 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Pearson, Jane L (NIH/NIMH) [E]
Subject: RE: **Request for your review: Suicide Vital Signs Fact Sheet

Deb –Thanks for the opportunity to comment on this important project. I have a number of comments , including suggestions for what I would regard as a better balance.

1) The fact sheet says suicide has greatly increased in 44 states and that in half the states that increase is more than 30%. Very important information but would be useful to specify what greatly means since it is below 30%. (After this is out, would be great to see the state by state breakdown that is summarized in the map and to discuss in the federal Working group).
2) Regarding balance I think it strikes the correct note in most places but with one significant exception : I do not agree with the following bullet point

ϒ/Despite the NSSP guidance, suicide prevention efforts are largely clinically-oriented, focused on treating mental health problems (MHP) and preventing re-attempts (6). I don't think this is at all true and can discourage and minimize the importance of efforts like Zero Suicide. This was not I what the Action Alliance/SAMHSA assessment of National Strategy implementation found. That report supports your basic conclusion that comprehensive suicide prevention efforts are needed and are not being done and hence the National Strategy is not being implemented in anything like the comprehensive coordinated way that is called for.but it is not because the field is too focused on clinical care for suicidal people. The field has for years been focused on non-clinical efforts such as awareness campaigns and gatekeeper training that treat the mental health system as a "black box" . The field has been using a larger public health lens to try to focus on identifying those who are already suicidal rather than preventing people from becoming suicidal, in essence a community oriented case finding approach is what has been most typical and that has clearly been the experience with the GLS grants. But the solution is not to deemphasize clinical care at precisely the time that Zero Suicide has been gaining a bit of traction. I would recommend saying instead . "Despite the NSSP guidance, The NSSP IAAG was, however, unable to find any state or community implementing the full range of comprehensive, coordinated, and effective suicide prevention efforts across all relevant settings and

populations. This is already cleared language so I would suggest referencing the NSSP Implementation Assessment group report . Similarly, I would edit the passage below suicide prevention research and practice is heavily oriented towards downstream treatment of MHP and prevention of reattempts. Additional focus on non-mental health factors, further upstream, is essential to a public health approach (10), as the current study found that more than half of suicide decedents in NVDRS did *not* have a known MHP. .. I would not want to characterize the relative emphasis in suicide prevention research but in practice this is not the case. Here I would say something along the lines of "much of suicide prevention practice has focused on identifying suicidal people in the community, so increased focus is needed on how to "move upstream" and prevent people from becoming suicidal people in the first place.

From: Stone, Deborah (CDC/ONDIEH/NCIPC) [mailto:zaf9@cdc.gov]
Sent: Thursday, April 05, 2018 12:49 PM
To: McKeon, Richard (SAMHSA/CMHS); Pearson, Jane L (NIH/NIMH) [E]; 'John Draper'
Subject: **Request for your review: Suicide Vital Signs Fact Sheet
Importance: High

Hi Richard, Jane, and John,

I hope you are doing well! As you are hopefully aware, CDC is releasing a Vital Signs on Suicide on June 5th. If you aren't familiar with *Vital Signs*, it began in 2010 and is a high profile monthly CDC publication widely distributed to highlight important public health threats and what can be done to prevent them. The release always includes a web page, an MMWR article, a translation piece (i.e. fact sheet), a press release, a telebriefing with the media by the CDC Director, a virtual town hall meeting, and other products. As you can imagine it's a lot of work! I am currently leading the effort but am assisted by many people.

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Wondering if you can respond by Monday noon with any comments on the fact sheet and any tweaks to wording in text below if you think it's not in balance. Also note that certain details have been omitted (some of which are actually in the fact sheet).

A note on the fact sheet: This draft is the result of our first (3 hr meeting) with the vital signs team. We've been told the fact sheet goes through like 200 revisions?! Everything in the fact sheet must also be stated in the MMWR and it has to be plain language. The fact sheet is 4 pages and came with 14 pages of guidance if that tells you anything! Attaching the latest opioid one for your convenience.

MMWR Abstract

Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
Deb Stone, Tom Simon, Katie Fowler, Scott Kegler, Keming Yuan, Kristin Holland, Asha Ivey-Stephenson, and Alex Crosby

Background: Suicide rates in the United States have risen nearly 30% since 1999. Mental health problems (MHP) are just one factor contributing to suicide. Examining state-level trends in, and the multiple contributing circumstances to, suicide can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among people aged ≥10 years, by state and sex, across six consecutive three-year periods (1999-2016), were assessed using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health problems (MHP).

Results: From 1999-2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases of more than 30%...In 2015, more than half (54%) of decedents in 27 states did not have a known MHP. Among people with circumstance information, several circumstances, including relationship problems/loss (45.1% vs 39.6%), life stressors (54.2% vs 49.7%), and recent/impending crises (32.9% vs 26.0%) were significantly more likely among those without a known MHP than decedents with MHP, but were common across groups.
Conclusions: Suicide rates increased significantly across most states from 1999-2016. Various circumstances contributed to suicides among people with and without known MHP.
Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support people at risk, prevent reattempts, and help friends/family after a suicide occurs.

Part of the Intro (Would like your thoughts on whether this is striking the right balance. This is my main reason for wanting your feedback. We want to make the case for a focus on the full range of factors impacting on suicide and the full range of prevention strategies without inadvertently sending the message that those other factors and other strategies aren't important. They definitely are. We need it all.

- The *National Strategy for Suicide Prevention(NSSP)*(5) calls for a public health approach to suicide prevention with efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal). Such an approach underscores that suicide is rarely caused by any single factor, but rather, is multi-determined.
- Despite the NSSP guidance, suicide prevention efforts are largely clinically-oriented, focused on treating mental health problems (MHP) and preventing re-attempts (6).
- Apart from MHP and prior attempts, other contributing circumstances to suicide include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, and poor coping and problem-solving skills (5). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them, can help reach the nation's goal of reducing suicide rates 20% by 2025 (7).

Part of the methods:

- Characteristics and circumstances of suicide decedents ≥10 years old, with and without known MHP, were compared in the 27 states with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015.
- NVDRS defines MHP as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (9), with the exception of alcohol and other substance dependence, which are captured separately in NVDRS.

Part of the results: [Main point: while there were specific differences between the groups, the main point is that both groups had multiple circumstances and so we need to be addressing all of these in our prevention activities]

- People without known MHP were less likely to have any substance abuse problems
- ...two-thirds of those with known MHP had a history of mental health or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment.
- Decedents without, versus those with, known MHP, had significantly greater likelihood of any relationship problem/loss, specifically intimate partner problems, arguments... They also were more likely to have experienced any life stressors, such as criminal-legal problems, or eviction/loss of home and were more likely to have had a crisis within the preceding or upcoming two weeks. All of these differences remained significant in the adjusted models.
- Among all people with crises, intimate partner problems were the most common types and did not differ by group.

- Similarly, among people without versus with MHP, physical health problems and job/financial problems were commonly experienced and did not differ by group.

Part of the discussion:

- ...Additional research into the specific causes of these trends is necessary. Fortunately, data from the 27 states participating in NVDRS provides important insight into suicide circumstances and can help states identify prevention priorities.
- ...suicide prevention research and practice is heavily oriented towards downstream treatment of MHP and prevention of reattempts. Additional focus on non-mental health factors, further upstream, is essential to a public health approach (10), as the current study found that more than half of suicide decedents in NVDRS did *not* have a known MHP. ..
- ...people with MHP also experienced other life stressors such as job/financial, relationship, and/or physical health problems. These findings point to the need to both prevent the conditions associated with mental health problems in the first place, and to support people with known MHP to decrease their risk of poor outcomes.
- Two-thirds of this group had a history of any mental health and/or substance abuse treatment, with over half in treatment when they died. This suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to behavioral health providers in underserved areas is needed, as is expansion of healthcare systems needed that integrates physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions (12).
- Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide...[insert technical package components here]
- Limitation--abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can impact data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often see greater attributions to mental disorders.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 9 Apr 2018 16:37:30 +0000
To: Pearson, Jane L (NIH/NIMH) [E]
Cc: Scanlon, Michaelle (NIH/NIMH) [C];McKeon, Richard (SAMHSA/CMHS);'John Draper'
Subject: RE: **Request for your review: Suicide Vital Signs Fact Sheet

Thank you very much, Jane. I appreciate yours and Michaelle's thorough review and for the other materials included. Will share the collective feedback from everyone with our working group today.

Deb

From: Pearson, Jane L (NIH/NIMH) [E]
Sent: Monday, April 9, 2018 12:16 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Scanlon, Michaelle (NIH/NIMH) [C] ; McKeon, Richard (SAMHSA/CMHS) ; 'John Draper'
Subject: RE: **Request for your review: Suicide Vital Signs Fact Sheet
Importance: High

Hi Deb,

Thanks again for allowing us to provide some input. I agree that we need to move towards a more 'balanced' portfolio of research based suicide prevention, and that is consistent with NAASP national strategy and the research agenda. I agree with Richard's comments that NAASP strategy is not focused on the health care system – that just happens to be where there is current momentum and accountability.

I have attached some comments/changes, and some are offered by Michaelle Scanlon, a communications staff member at NIMH.

You might consider the attached article by Chen as a way of thinking about how more community-based prevention efforts can also reduce the burden on the health care system, as well as reducing health disparities (this group is now looking at reduction of suicide benefits). You could also note that early prevention of high risk behaviors (consistent with CDC support of social connection as protective) might have suicide preventive outcomes, as well as other benefits in the long run: https://onlinelibrary.wiley.com/toc/1943278x/46/S1

Jane

Jane L. Pearson, PhD

Chair, NIMH Suicide Research Consortium

Division of Services and Intervention Research

National Institute of Mental Health

6001 Executive Blvd.

Room 7157, MSC 9629

Bethesda, MD 20892

Email: jpearson@nih.gov

Office: 301.443.3598

Fax : 301.443.4045

Address for FedEx, UPS, etc

6001 Executive Blvd, RM 7144

Rockville, MD 20852

If you are interested in suicide research,

please see www.suicide-research-agenda.org

From: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>
Sent: Thursday, April 5, 2018 12:49 PM
To: McKeon, Richard (SAMHSA/CMHS) <Richard.McKeon@samhsa.hhs.gov>; Pearson, Jane L (NIH/NIMH) [E] <jpearson@mail.nih.gov>; 'John Draper' <JohnD@mhaofnyc.org>
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Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support people at risk, prevent reattempts, and help friends/family after a suicide occurs.

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Cc: Scanlon, Michaelle (NIH/NIMH) [C];McKeon, Richard (SAMHSA/CMHS);'John Draper'
Subject: RE: **Request for your review: Suicide Vital Signs Fact Sheet
Attachments: Suicide Vital Signs Fact Sheet after roundtable to share 4.4.18 jp ms.docx, MMWR Abstract comments to Deb Stone from JP MS.docx, Chen et al 2017 Preventing hospitalization disparity via health promotion.pdf
Importance: High

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Thanks again for allowing us to provide some input. I agree that we need to move towards a more 'balanced' portfolio of research based suicide prevention, and that is consistent with NAASP national strategy and the research agenda. I agree with Richard's comments that NAASP strategy is not focused on the health care system – that just happens to be where there is current momentum and accountability.
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https://onlinelibrary.wiley.com/toc/1943278x/46/S1
Jane
Jane L. Pearson, PhD
Chair, NIMH Suicide Research Consortium
Division of Services and Intervention Research
National Institute of Mental Health
6001 Executive Blvd.
Room 7157, MSC 9629
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Email: jpearson@nih.gov
Office: 301.443.3598
Fax : 301.443.4045
Address for FedEx, UPS, etc
6001 Executive Blvd, RM 7144
Rockville, MD 20852
If you are interested in suicide research,
please see www.suicide-research-agenda.org

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Sent: Thursday, April 5, 2018 12:49 PM
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Part of the discussion:

- ...Additional research into the specific causes of these trends is necessary. Fortunately, data from the 27 states participating in NVDRS provides important insight into suicide circumstances and can help states identify prevention priorities.
- ...suicide prevention research and practice is heavily oriented towards downstream treatment of MHP and prevention of reattempts. Additional focus on non-mental health factors, further upstream, is essential to a public health approach (10), as the current study found that more than half of suicide decedents in NVDRS did *not* have a known MHP. ..
- ...people with MHP also experienced other life stressors such as job/financial, relationship, and/or physical health problems. These findings point to the need to both prevent the conditions associated with mental health problems in the first place, and to support people with known MHP to decrease their risk of poor outcomes.
- Two-thirds of this group had a history of any mental health and/or substance abuse treatment, with over half in treatment when they died. This suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies.

Additionally, greater access to behavioral health providers in underserved areas is needed, as is expansion of healthcare systems needed that integrates physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions (12).

- Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide…[insert technical package components here]
- Limitation--abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can impact data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often see greater attributions to mental disorders.

Rising suicide rates across states

More than just a mental health problem

45,000

Nearly 45,000 suicides in 2016

30%

Suicide rates increased more than 30% in half of states in the US

50%

More than half of the people who died by suicide did not have a known mental health problem

Suicide is a leading cause of death in the US and has greatly increased in 44 states (1999-2016). Mental health problems are often seen as the sole cause, but suicide is a complex event and rarely caused by a single factor. Many people who die by suicide have not received a mental health diagnosis through the health care system, and are either undiagnosed, or may~~are not known to~~not have mental health problems at the time of death. Other issues also contribute to suicide, including stressors such as failing relationships, poor health, job stress or unemployment, money, housing, and legal problems; inadequate coping strategies, and inadequate social support. Close coordination of civic, law enforcement, business, education, social services, faith, media, and health sectors is important for preventing suicide. States and communities can take actions now based on the best available evidence. State public health departments can be the leaders in bringing together the necessary community partners for action.

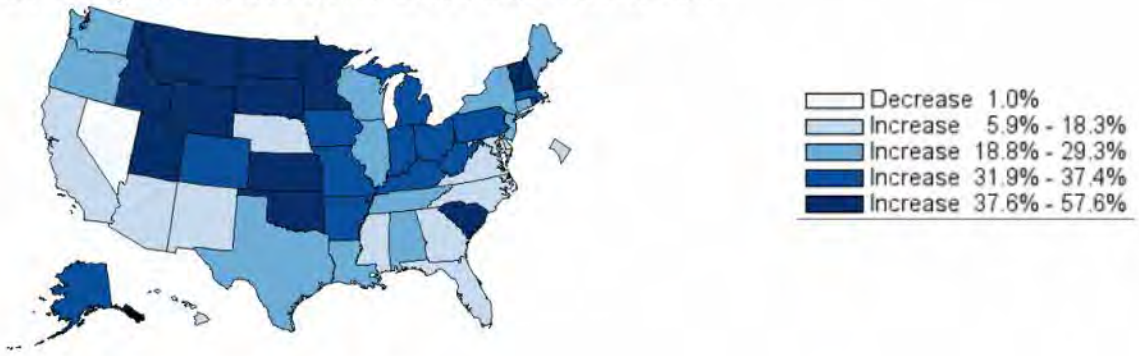
States and communities can:

- Identify and support people at risk of suicide.
- Lessen harms and prevent future risk of suicide.
- Teach coping and problem-solving skills to help youth and adults manage ~~everyday~~ stressful challenges.
- Create safe and supportive environments where people live, work, learn, and play.
- Make sure people are connected to others in their community and don't feel alone.
- Make sure those at risk are connected to healthcare systems that include mental and physical healthcare.
- Strengthen temporary financial and housing assistance for those struggling to make ends meet.

[INCLUDE LINK TO TECHNICAL PACKAGE:
www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf]

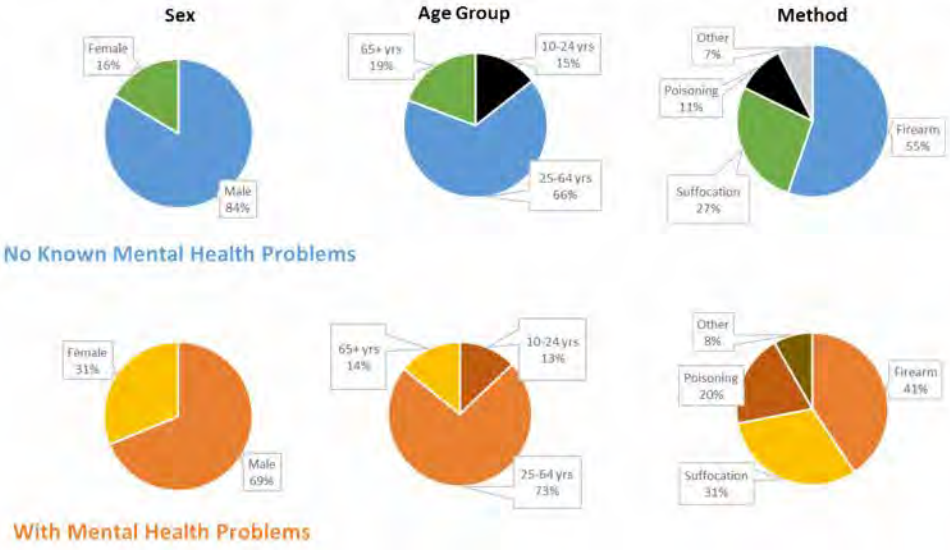
Problem: State suicide rate increases ranged from 6% to 58%

Deaths by suicide rose across the US from 1999 to 2016



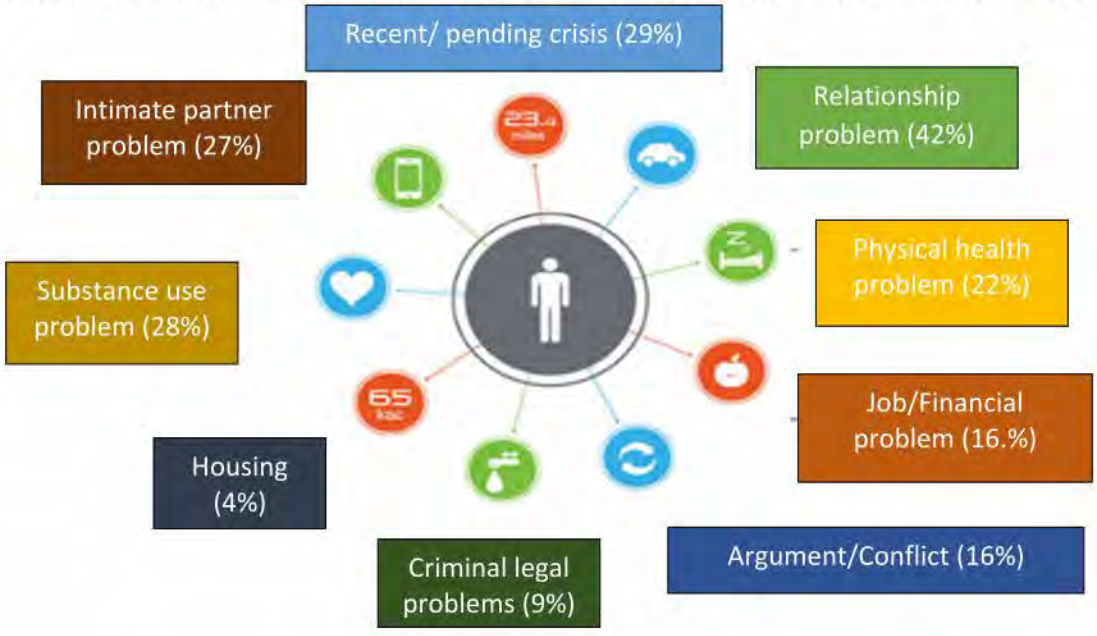
Many factors contribute to suicide

- 54% of people who died by suicide did not have a known mental health problem.



- Many factors contribute to suicide among those with and without mental health problems.

[Note: Icons below will be changed to reflect the problem listed. This is just to convey the idea]



States are seeing increases. What can they do prevent suicides?

Use *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* to make decisions based on the best evidence for suicide prevention **[This could be in a banner going across the page with the link to the technical package www.cdc.gov/violenceprevention/pub/technical-packages.html]**



[Create an infographic like the one below that lists warning signs. It will be updated to reflect the latest guidance on warning signs]



WHAT CAN BE DONE



The Federal government is:

- Tracking and monitoring the problem.
- Sharing information on actions proven to prevent suicide.
- Working with other local, state, and federal governmental agencies to prevent suicide.

States and communities can:

- Identify and support people at risk of suicide.
- Lessen harms and prevent future risk of suicide.
- Teach coping and problem-solving skills to help youth and adults manage ~~everyday~~ stressful challenges.
- Create safe and supportive environments where people live, work, learn, and play.
- Make sure people are connected to others in their community and don't feel alone.
- Make sure those at risk are connected to healthcare systems that include mental and physical health.
- Strengthen temporary financial and housing assistance for those struggling to make ends meet.
- Help the general public identify someone in need – share the warning signs.
- Help the general public know that one person can make a difference. Share the 5 Action Steps for Helping Someone in Emotional Pain.

Healthcare systems can

- Make sure entire healthcare systems provide high quality, ongoing care, focusing on suicide prevention.
- Make sure healthcare is easily accessible and provide options such as telecommunications in areas where services aren't available.
- Provide personalized, proven treatment plans for patients at risk of suicide.

Media can:

- Adopt best practices in order to write a story that does not contribute to suicide contagion. Read and share the Recommendations for Reporting on Suicide.

Employers can:

- Promote employee health and well-being, support people at risk, and have plans in place to respond to risk effectively.
- Train all employees about suicide risk and prevention.
- Encourage employees to seek help and provide referrals to mental health, substance abuse, or financial counseling services as needed.

Everyone can:

- Reduce access to lethal means, such as medications and firerams, among people at risk.
- Learn the warning signs of suicide to help identify and refer people at risk.

Comment [SM([]: https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml#part_153220

Comment [SM([]: http://reportingonsuicide.org

- Contact the National Suicide Prevention Lifeline for help for themselves or others: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org/

[Call out box: The media can encourage help-seeking and avoid dramatic headlines using guidelines at www.ReportingOnSuicide.org]

MMWR Abstract

Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
Deb Stone, Tom Simon, Katie Fowler, Scott Kegler, Keming Yuan, Kristin Holland, Asha Ivey-Stephenson, and Alex Crosby

Background: Suicide rates in the United States have risen nearly 30% since 1999. There is no single cause of suicidal behavior. Mental health problems (MHP) among suicide decedents are often identified through health care visits, and individuals seeking mental health services are at elevated risk for suicide. However, many other factors can ~~be a~~ contribute to suicide risk. ~~Ingare just one factor, contributing to suicide.~~ Examining state-level trends ~~in,~~ and the multiple contributing circumstances to ~~,~~ suicide can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among people aged ≥10 years, by state and sex, and across six consecutive three-year periods (1999-2016), were assessed using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health problems (MHP).

Results: From 1999-2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases of more than 30%. ~~.~~In 2015, more than half (54%) of decedents in 27 states did not have a known MHP. Among people with circumstance information, several circumstances, including relationship problems/loss (45.1% vs 39.6%), life stressors (54.2% vs 49.7%), and recent/impending crises (32.9% vs 26.0%) were significantly more likely among those without a known MHP than decedents with MHP, but were common across groups.

Conclusions: Suicide rates increased significantly across most states from 1999-2016. Various circumstances contributed to suicides among people with and without known MHP.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support people at risk, prevent reattempts, and help friends/family after a suicide occurs.

Part of the Intro (Would like your thoughts on whether this is striking the right balance. This is my main reason for wanting your feedback. We want to make the case for a focus on the full range of factors impacting on suicide and the full range of prevention strategies without inadvertently sending the message that those other factors and other strategies aren't important. They definitely are. We need it all.

- The *National Strategy for Suicide Prevention(NSSP)* (5) calls for a public health approach to suicide prevention with efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal). Such an approach underscores that suicide is rarely caused by any single factor, but rather, is multi-determined.
- Despite the NSSP guidance, suicide prevention efforts are largely clinically-oriented, focused on treating mental health problems (MHP) and preventing re-attempts (6).
- Apart from MHP and prior attempts, other ~~contributing~~ circumstances contributing to suicidal thoughts and behaviorse include inadequate coping and problem-solving skills, inadequate support resources, social and economic problems, and access to lethal means (e.g., substances, firearms, bridges) ~~among people at risk, and poor coping and problem-solving skills~~ (5). Expanded awareness of these additional circumstances contributing to suicide risk and taking action to address them, can help communities and states reach the nation's goal of reducing suicide deaths~~rates~~ 20% by 2025 (7).

Part of the methods:

- Characteristics and circumstances of suicide decedents ≥10 years old, with and without known MHP, were compared in the 27 states with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015.
- NVDRS defines MHP as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (9), with the exception of alcohol and other substance dependence, which are captured separately in NVDRS.

Part of the results: [Main point: while there were specific differences between the groups, the main point is that both groups had multiple circumstances and so we need to be addressing all of these in our prevention activities]

- People without known MHP were less likely to have any substance abuse problems.
- ...Ttwo-thirds of those with known MHP had a history of mental health or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment.
- Compared to decedents with MHP, ddecedents without a, versus those with, known MHP, had significantly greater likelihood of having any relationship problem/loss, specifically intimate partner problems, including loss and arguments.... They also were more likely to have experienced any life stressors, such as criminal or legal problems, or eviction/loss of home, and were more likely to have had aexperienced or anticipated a crisis within the preceding or upcoming two weeks of death. All of these differences remained significant in the adjusted models.
- Among all people with crises, intimate partner problems were the most common types and did not differ by group.
- Similarly, among all decedents, people without versus with MHP, physical health problems and job/financial problems were commonly experienced by those with a known MHP and those without a known MHP.and did not differ by group.

Part of the discussion:

- ...Additional research into the specific causes of these trends is necessary. Fortunately, data from the 27 states participating in NVDRS provides important insight into suicide circumstances and can help states identify prevention priorities.
- S...ssuicide prevention research and practice is heavily oriented towards downstream treatment of MHP and prevention of reattempts. Additional focus on non-mental health factors, further upstream, is essential to a public health approach (10), as the current study found that more than half of suicide decedents in NVDRS did *not* have a known MHP.....
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- Two-thirds of this group had a history of any mental health and/or substance abuse treatment, with over half in treatment when they died. This suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to behavioral health providers in underserved areas is needed. E, as is expansion of healthcare systems needed that integrates physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions is also needed (12).

Comment [SM([]: Does this mean all decedents or just decedents with a known MHP?

- Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide…[insert technical package components here]
- Limitation--abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can impact data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often see greater attributions to mental disorders.

American Journal of
Preventive Medicine

RESEARCH ARTICLE

Reducing Preventable Hospitalization and Disparity: Association With Local Health Department Mental Health Promotion Activities

Jie Chen, PhD,[1] Robin Bloodworth, PhD,[1] Priscilla Novak, MPH,[1] Benjamin Le Cook, PhD,[2] Howard H. Goldman, MD, PhD,[3] Michael S. Rendall, PhD,[4,5] Stephen B. Thomas, PhD,[1,5,6] Charles F. Reynolds III, MD[7]

Introduction: Serving as the center of community-engaged health programs, local health departments can play a critical role in promoting community mental health. The objectives of this study were to explore the association between local health department activities and (1) preventable hospitalizations for individuals with mental disorders, and (2) associated racial disparities in preventable hospitalizations.

Method: Employing the linked data sets of the 2012–2013 Healthcare Cost and Utilization Project state inpatient discharge file of the State of Maryland, the National Association of County and City Health Officials Profiles Survey, the Area Resource File, and U.S. Census data, the authors estimated the association between local health department activities (i.e., provision of mental health preventive care and community mental health promotion) and the reduction of the preventable hospitalizations for ambulatory care–sensitive conditions and coexisting mental disorders. All the data analyses were conducted during September 2016–August 2017.

Results: Multilevel regression showed that local health departments' provision of mental health preventive care (OR=0.76, 95% CI=0.63, 0.92) and mental health promotion activities (OR=0.77, 95% CI=0.62, 0.94) were significantly associated with lower rates of preventable hospitalizations for individuals with ambulatory care–sensitive conditions and coexisting mental disorders. Decomposition results suggested that local health departments' direct provision of mental health preventive care could reduce 9% of the racial disparities.

Conclusions: Improving care coordination and integration are essential to meeting the growing demands for healthcare access, while controlling costs and improving quality of service delivery. These results suggest that it will be effective to engage local health departments in the integrated behavioral health system.

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INTRODUCTION

The cost of mental illness reached $201 billion in the U.S. in 2013, topping the list of the most costly conditions.[1] Nearly 34 million adults—17% of all American adults—had co-occurring mental and physical conditions.[2] Racial and ethnic minority patients experience disproportionate burdens of common physical health conditions associated with mental illness, largely as a result of lack of healthcare access and social stigma.[3,4] Effectively treating mental illness and associated conditions depends on a culturally tailored and comprehensive infrastructure that crosses health systems.[5,6] However, the current mental health care system works in a silo.[7]

Integration of physical and mental health care has been considered as an effective approach to improving care for individuals with coexisting mental disorders and other physical health conditions.[8,9] Most of the care integration models focus on primary care settings, behavioral health settings, and health homes.[8–10] Examples of successful integration of mental and physical care include the PROSPECT Trial, which has effectively reduced depressive symptoms,[11] and Behavioral Health Associates, operated as part of UCLA Health, which has led to reduction in emergency department use.[12]

Recent research suggests that provision of evidence-based mental health care could be expanded beyond primary care to local health departments (LHDs).[13–17] LHDs function within the Centers for Disease Control's Public Health Model of Practice and are called upon to serve in central roles of public health assessment, policy development, and assurance of service delivery.[13,18,19] Emerging evidence has shown that LHDs have been actively providing healthcare services and population-based interventions to address mental health issue.[13,18] To the authors' knowledge, there is still a lack of evidence directly linking LHDs' activities with community mental health.[20,21]

This study constructed (Figure 1) an ecologic multilevel model to delineate the roles of LHDs to promote mental health and reduce racial and ethnic health disparities.[9,22–25] As the center of community-engaged health programs, and the major source of health care for vulnerable populations, LHDs can promote mental health by providing critical healthcare resources, especially for people with limited healthcare access.[20,21,26] LHDs are well-established organizations within their communities, and this gives them an advantage in terms of cultivating trusting relationships with minorities and low-income residents to improve engagement in health care.[27] Lastly, because assessment of community needs forms the basis for public health practice, LHDs' activities are more likely to reflect community health needs

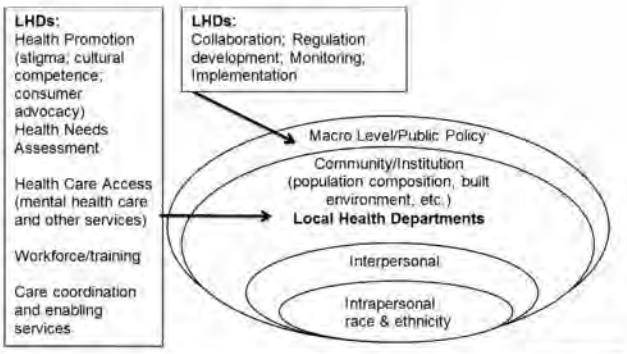


Figure 1. An ecological perspective on local health departments' role in improving mental health.
Note: The model is adapted from the social ecological model (McLeroy et al.[22] and Stokols et al.[24]) and the CDC Public Health Action Plan 2011. LHDs, local health departments.

and values, and thereby provide needed education to target barriers such as stigmatization and negative beliefs about mental health conditions.[28,29]

This present study focuses on the roles of LHDs in reducing preventable hospitalizations for individuals with mental disorders and coexisting chronic conditions. The concept of ambulatory care–sensitive conditions (ACSCs) was used to define preventable hospitalizations.[30] ACSCs are medical problems, such as diabetes and hypertension that can be well managed through routine, ongoing care in an office-based setting. More than 40% of preventable hospitalizations for ACSCs are linked to mental disorders (such as mood, anxiety, schizophrenia, and psychotic disorders).[31] This study hypothesizes that LHD's involvement in the provision of mental health preventive care and health promotion could reduce preventable hospitalizations and reduce associated racial disparities for individuals with coexisting mental and physical conditions.

METHODS

Study Sample

Data from the State of Maryland were used to test hypotheses. Specifically, this study employed the linked data sets of the 2012–2013 Healthcare Cost and Utilization Project State Inpatient Databases of the State of Maryland, the National Association of County and City Health Officials Profiles Survey,[32] the American Hospital Directory, the Area Health Resource File, and U.S. Census data. All the data sets are public data files. The analytic sample includes hospital discharges in 2012–2013 for adults aged 18–64 years (N=296,917). All hospitals in this analysis are short-term acute care, voluntary, non-profit hospitals. The American Hospital Directory was used to verify hospital characteristics.

Maryland has 24 LHDs, and the communities they serve vary widely in terms of SES, ethnic and racial characteristics, and behavioral health disorder prevalence. The jurisdiction areas of LHDs are at the county level. The State of Maryland is advancing

the State Innovation Model to promote the efficiency and equity of its healthcare delivery system[33] and LHDs play leadership roles in this model. In addition, care coordination is critically important under the Maryland Global Budget Revenue Program, which pushes hospitals to target population health.[34] Maryland stands at a critical juncture in its understanding of how to involve LHDs in integrated healthcare delivery models, in order to achieve the state's goal of improved population health, especially for the most vulnerable, within the fixed economic resources the state can allocate to health care.

Measures

The outcome variable of interest was the probability of having a preventable hospitalization for coexisting ACSCs and mental illness. ACSCs were measured using the Agency for Healthcare Research and Quality's Prevention Quality Indicators™, Version 5.0.[35] This study used the Agency for Healthcare Research and Quality's report on mental disorders as the reference to define patients with mental disorders.[36] Broad patient populations with mental and substance use disorders (such as miscellaneous mental conditions, alcohol-related disorders, drug abuse disorders, etc.) were first examined. Research suggests that mental disorders, such as depression and anxiety disorders, can be effectively treated and prevented.[37,38] Hence, this study also focused on developing effect estimators of LHDs' activities among patients with depression and anxiety disorders (i.e., a subset of mental disorders) in particular. Appendix Table 1 lists specified ICD-9 codes for each of the mental disorders.[36]

Derived from the ecologic multilevel model presented in Figure 1, LHDs can improve community mental health and reduce racial disparities by providing timely health care and culturally designed patient education programs.[39,40] This study examined the role of LHDs from two perspectives: (1) LHDs' active provision of mental health preventive care (i.e., LHDs directly performed preventive care for mental disorders versus LHDs that had no direct involvement). Preventive care includes initial screening and case detection, identifying, and tracking those at high risk for relapse and those not adhering to treatment, structuring follow-up, monitoring outcomes, and providing targeted services for treatment-resistant or more complex cases; and (2) LHDs' active health promotion. LHDs' health promotion was considered active if LHDs had been involved in policy or advocacy activities focused on mental health, tobacco, alcohol, or other drugs, chronic conditions, education, and affordable housing. Both measures were provided in the National Association of County and City Health Officials Profiles Survey data set.

These integrated data from multiple data sources enabled an examination of the impact of LHDs, while considering complex patient demographic and socioeconomic factors, cultural background, health needs,[3,41] and contextual factors[42,43] that might relate to health care and heath disparities for patients with mental disorders. Specifically, this study used the Andersen Behavioral Model of Health Services Use[44] to control for predisposing factors (age, gender, and race); need factors (Elixhauser comorbidity index); and enabling factors (insurance coverage, income in patients' residential ZIP code). Contextual factors included urban or rural area, the percentage of the county population that report African American ancestry, the percentage of county population without high school degrees, and the percentage of county population with insurance. Measures indicating availability of mental healthcare resources were also included[45,46]: the number of community mental health centers, the number of federally qualified health centers, the number of primary care doctors, and physicians specializing in mental health care. LHDs' characteristics, such as whether an LHD had one or more local boards of health, the total full-time equivalents workforce at an LHD, and an LHD's total expenditures per capita were also controlled in the model.[26,46]

Statistical Analysis

A multilevel/hierarchical model was used to examine whether LHDs' active provision of mental health preventive care and health promotion could reduce the rates of preventable hospitalizations. Multilevel models were used to measure variability across individuals within a hospital and an LHD, across hospitals within an LHD, and across LHDs and account for the non-independence of individuals living in the same area.[47]

$$E(Y_{ihl}) = \beta_0 + \beta_X X_i + \beta_H H_i + \beta_L L_i + d_{hl} + e_{ihl}$$

$$d_{hl} \sim N\left(\beta_h H_h + c_l,\ \delta_h^2\right),$$

$$c_l \sim N\left(\beta_L LHD_l,\ \delta_l^2\right),$$

where Y is the outcome variable, X is a vector of individual characteristics, H are measures of hospital characteristics, LHD are measures of service provision or health promotion.

The Blinder–Oaxaca regression decomposition method was used to identify and quantify specific LHD practices affecting racial disparities (white versus African American) in the likelihood of having a preventable hospitalization.[48,49] The decomposition method approach is a regression-based method.[48] To decompose the difference in the probability of having preventable hospitalizations between whites and African Americans, $\overline{Y}^{W} - \overline{Y}^{AA}$, multivariable logistic regressions $Y = F(X\beta)$ for these two groups were first estimated separately. The decomposition for these nonlinear equations was written as

$$\overline{Y}^{W} - \overline{Y}^{AA} = \left[\sum_{i=1}^{N^{W}} \frac{F\left(X_i^{W} \hat{\beta}^{W}\right)}{N^{W}} - \sum_{i=1}^{N^{AA}} \frac{F\left(X_i^{AA} \hat{\beta}^{W}\right)}{N^{AA}}\right] + \left[\sum_{i=1}^{N^{AA}} \frac{F\left(X_i^{AA} \hat{\beta}^{W}\right)}{N^{AA}} - \sum_{i=1}^{N^{AA}} \frac{F\left(X_i^{AA} \hat{\beta}^{AA}\right)}{N^{AA}}\right]$$

where W stands for whites and AA stands for African Americans. The first term on the right-hand side measures the portion of the difference because of observed population characteristics (i.e., all of the control variables), and the second term measures the portion of the difference because of unobserved heterogeneities, such as cultural background and stigma. Among the observed population characteristics, disparities associated with each specific factor, such as LHD activities, can also be quantified. This method has been widely adopted to examine racial and ethnic disparities in health care.[43,50,51]

A variety of sensitivity analyses, such as different model specifications, were conducted to evaluate the robustness of the model, and found similar results. Stata, version 14, was used for the analyses.

RESULTS

Table 1 presents the rates of preventable hospitalizations and LHDs' activities for patients with mental disorders. The rate of preventable hospitalizations was double among African American patients (10% vs 5%), compared with white patients. Among those with preventable hospitalizations, 51% of African Americans and 65% of whites were diagnosed with any mental health disorder.

African Americans, both overall and among those with mental illness who had preventable hospitalizations, were less likely than whites to live in the counties with LHDs that were active in the provision of mental health preventive care. Among adults who experienced hospitalizations, ≅55% of whites and 38% of African Americans lived in counties with direct LHDs preventive care provision. Among patients with mental illness who had preventable hospitalizations, 49% of whites and 29% of African Americans were from counties with direct LHDs preventive care provision. The large majority of LHDs in the state of Maryland had actively promoted policies and activities that can improve mental health (covering 96% of whites and 99% of African Americans).

Results of multilevel regressions (Table 2) suggested that preventable hospitalizations rates for individuals with mental illness were significantly lower if LHDs directly provided mental health preventive care (OR=0.76, 95% CI=0.63, 0.92, and OR=0.77, 95% CI=0.62, 0.94, for individuals with co-occurring ACSCs and mental and substance use disorders, and depressive and anxiety disorders, respectively). Rates of preventable hospitalizations for individuals with mental illness were also significantly lower if LHDs were actively involved in health promotion (OR=0.76, 95% CI=0.56, 1.02, and OR=0.75, 95% CI=0.57, 0.99, respectively). Results also showed that the likelihood of mental illness–related

Table 1. Race-Related Rates of Preventable Hospitalizations for Individuals With Mental Illness

Variables	% total (*n*=296,917) M (SD)	% white, M (SD) (*n*=148,643)	% African American, M (SD) (*n*=119,610)
Hospitalization rates			
Hospitalization rates for any ACSCs	6.71 (25.02)	**4.97***** (21.73)	**9.75***** (29.66)
Hospitalization rates for any ACSCs and mental and substance use disorder	3.32 (17.93)	**3.24***** (17.69)	**4.98***** (21.76)
Hospitalization rates for any ACSCs and depressive/anxiety disorder	3.74 (18.99)	**2.87***** (16.69)	**4.43***** (20.57)
Among individuals with hospitalizations for any ACSCs			
Rates of having a mental and substance use disorder	55.80 (49.66)	**65.09***** (47.67)	**51.15***** (49.99)
Rates of having depressive/anxiety disorder	49.53 (49.99)	**57.73***** (49.40)	**45.45***** (49.79)
Local health departments (LHDs) of the state of Maryland			
LHD direct provision of mental health preventive care	47.27 (49.93)	**55.28***** (49.72)	**37.53***** (48.42)
LHD active involvement in health promotion	97.44 (15.79)	**96.25***** (19.00)	**98.81***** (10.83)
Among individuals with hospitalizations for any ACSCs and mental and substance use disorder			
Rates of living in the counties with LHDs' direct provision of mental health preventive care	38.17 (48.48)	**48.83***** (49.99)	**28.98***** (45.37)
Rates of living in the counties with LHDs' active involvement in health promotion	97.59 (15.34)	**96.48***** (18.44)	**98.60***** (11.77)

Source: 2012–2013 Health Cost and Utilization Project State Inpatient Databases of the State of Maryland, the National Association of County and City Health Officials Profiles Survey (NACCHO).

Note: Boldface indicates statistical significance (*$p<0.05$; **$p<0.01$; ***$p<0.001$) (white versus African American). The NACCHO data provide a comprehensive description of LHD infrastructure and practice, including LHD resources, and services. The response rate of NACCHO survey was 78%, and the responding agencies cover more than 90% of the U.S. population each survey year. All the 24 counties in the state of Maryland were included in the estimation of LHDs preventive care; 23 counties were included in the estimation of LHDs promotion (Montgomery County Health Department did not report this measure in 2012). Maryland hospital inpatient file 2012 included 303,110 discharges for patients aged 18–64 years with the routine source of admission. There were 6,193 observations (approximately 2% of the total discharges) with missing age, gender, health insurance, and primary diagnosis code. The final sample size was 296,917. LHD measures were derived from the survey questions on "population-based primary prevention activities on mental health care" and "policy promotions." Representatives of each responding LHD checked the survey question on "how your LHD and other organizations provided that activity or service in your jurisdiction during the past year" (NACCHO data). Sample includes adults aged 18–64 years with all races and ethnicities (white, African American, Hispanic, Asian, Native, and other). ACSCs are measured using the AHRQ's Prevention Quality Indicators, Version 5.0. The AHRQ's report on mental disorders was used as reference to define patients with mental disorders. Appendix Tables 1 and 2 (available online) provide specified ICD-9 codes for ACSCs and mental disorders. Depression/anxiety is a subset of mental and substance use disorder. Specific ICD-9 codes used to measure specific mental illness are included in Appendix Table 2 (available online).

ACSCs, ambulatory care sensitive conditions; AHRQ, the Agency for Healthcare Research and Quality; LHD, local health department.

Table 2. Association Between LHDs' Mental Health Activities With Preventable Hospitalizations for Individuals With Mental Illness

Variables	ACSCs + mental and substance use disorder, OR (95% CI)	ACSCs + depression/ anxiety, OR (95% CI)	ACSCs + mental and substance use disorder, OR (95% CI)	ACSCs + depression/ anxiety, OR (95% CI)
Local health departments (LHDs)				
No direct LHD mental health preventive care	ref	ref		
Direct provision of mental health preventive care	**0.76** (0.63, 0.92)**	**0.77** (0.62, 0.94)**		
No active health promotion to improve community mental health			ref	ref
Health promotion to improve community mental health			0.76 (0.56, 1.02)	**0.75** (0.57, 0.99)*
Race				
White	ref	ref	ref	ref
African American	1.21 (1.10, 1.32)	**1.22** (1.10, 1.34)***	**1.22** (1.11, 1.34)***	**1.23** (1.10, 1.36)***
Hispanic	**0.61** (0.48, 0.78)***	**0.60** (0.47, 0.76)***	**0.62,** (0.46, 0.83)***	**0.59** (0.44, 0.79)***
Asian	**0.50** (0.38, 0.65)***	**0.49** (0.39, 0.62)***	**0.49** (0.36, 0.67)***	**0.47** (0.37, 0.61)***
Native	0.86 (0.42, 1.75)	0.70 (0.35, 1.41)	0.87 (0.39, 1.94)	0.66 (0.29, 1.50)
Other	**0.45** (0.31, 0.65)***	**0.43** (0.29, 0.64)***	**0.39** (0.26, 0.57)***	**0.36** (0.23, 0.56)***
Age	**1.15** (1.12, 1.18)***	**1.17** (1.15, 1.20)***	**1.15** (1.12, 1.18)***	**1.17** (1.15, 1.20)***
Age × Age	**1.00** (1.00, 1.00)***	**1.00** (1.00, 1.00)***	**1.00** (1.00, 1.00)***	**1.00** (1.00, 1.00)***
Female	0.97 (0.90, 1.04)	0.99 (0.92, 1.06)	0.98 (0.92, 1.05)	1.00 (0.93, 1.08)
Elixhauser comorbidity score	**1.10** (1.08, 1.13)***	**1.06** (1.03, 1.09)***	**1.10** (1.07, 1.12)***	**1.05** (1.02, 1.08)***
Insurance				
Uninsured	ref	ref	ref	ref
Medicare	0.90 (0.81, 1.01)	**0.80** (0.72, 0.90)***	0.91 (0.81, 1.02)	**0.80** (0.71, 0.90)***
Medicaid	0.96 (0.87, 1.06)	0.91 (0.82, 1.01)	0.95 (0.87, 1.05)	**0.90** (0.81, 1.00)*
Private insurance	**0.52** (0.46, 0.58)***	**0.48** (0.43, 0.54)***	**0.52** (0.46, 0.58)***	**0.48** (0.43, 0.54)***
Other	**0.68** (0.49, 0.94)*	**0.64** (0.45, 0.90)**	**0.67** (0.48, 0.93)*	**0.63** (0.44, 0.90)**
Admission type				
Emergency or urgent	ref	ref	ref	ref
Elective	**0.12** (0.09, 0.17)***	**0.12** (0.08, 0.17)***	**0.12** (0.09, 0.17)***	**0.12** (0.08, 0.17)***
Other type	**0.08** (0.02, 0.38)***	**0.08** (0.02, 0.41)***	**0.08** (0.02, 0.38)***	**0.08** (0.02, 0.41)***
Staffed beds				
<50	ref	ref	ref	ref
50–99	0.69 (0.45, 1.07)	0.73 (0.49, 1.09)	0.78 (0.49, 1.26)	0.84 (0.54, 1.30)
100–199	**0.57** (0.36, 0.91)*	**0.58** (0.37, 0.90)*	0.62 (0.37, 1.02)	0.63 (0.38, 1.02)
200–425	**0.42** (0.27, 0.65)***	**0.43** (0.28, 0.64)***	**0.45** (0.28, 0.70)***	**0.45** (0.29, 0.70)***

(continued on next page)

Table 2. Association Between LHDs' Mental Health Activities With Preventable Hospitalizations for Individuals With Mental Illness *(continued)*

Variables	ACSCs + mental and substance use disorder, OR (95% CI)	ACSCs + depression/ anxiety, OR (95% CI)	ACSCs + mental and substance use disorder, OR (95% CI)	ACSCs + depression/ anxiety, OR (95% CI)
>425	**0.27** (0.16, 0.46)***	**0.28** (0.16, 0.47)***	**0.28** (0.16, 0.48)***	**0.29** (0.17, 0.50)***
Median household income of residents in the patient's ZIP code				
Q1 (1–38,999)	ref	ref	ref	ref
Q2 (39,000–47,999)	0.90 (0.81, 1.01)	**0.89** (0.78, 1.00)*	0.90 (0.81, 1.01)	**0.88** (0.78, 1.00)*
Q3 (48,000–62,999)	**0.77** (0.71, 0.84)***	**0.75** (0.69, 0.82)***	**0.77** (0.71, 0.85)***	**0.75** (0.69, 0.82)***
Q4 (≥63,000)	**0.64** (0.56, 0.74)***	**0.62** (0.54, 0.72)***	**0.64** (0.56, 0.74)***	**0.62** (0.54, 0.72)***
Urban	1.38 (0.83, 2.27)	1.31 (0.81, 2.13)	0.99 (0.58, 1.70)	0.92 (0.55, 1.53)
County-level characteristics				
Percent of African Americans	**2.59** (1.38, 4.87)***	**2.79** (1.41, 5.51)***	0.68 (0.25, 1.80)	0.62 (0.23, 1.69)
Percent of foreign-born	**0.22** (0.09, 0.54)***	**0.18** (0.07, 0.47)***	0.71 (0.17, 2.95)	0.72 (0.16, 3.23)
Number of primary doctors, per 1,000 residents	0.91 (0.45, 1.84)	0.99 (0.47, 2.09)	**0.41** (0.17, 0.97)*	0.41 (0.16, 1.02)
Number of mental health specialists, per 1,000 residents	0.98 (0.72, 1.35)	0.95 (0.68, 1.33)	**1.71** (1.08, 2.71)*	**1.74** (1.09, 2.79)*
LHD per cap expenditure below median	ref	ref	ref	ref
LHD per cap expenditure above median	**0.74** (0.60, 0.91)***	**0.73** (0.58, 0.92)**	**0.69** (0.55, 0.86)***	**0.69** (0.54, 0.89)***
LHD per cap expenditure unknown	0.72 (0.47, 1.11)	0.71 (0.42, 1.17)	**0.59** (0.38, 0.90)**	**0.57** (0.34, 0.96)*
Constant	**0.01** (0.00, 0.06)***	**0.01** (0.00, 0.06)***	**0.00** (0.00, 0.02)***	**0.00** (0.00, 0.01)***
Log pseudo-likelihood	-38385.21	-41640.072	-36958.578	-40050.668
Wald chi-square	10518.97 ***	9215.92***	6021.20***	7304.72***

Source: The linked data sets of the 2012–2013 Health Cost and Utilization Project State Inpatient Databases of the State of Maryland, the National Association of County and City Health Officials Profiles Survey, the American Hospital Directory, the National Directory of Mental Health Treatment Facilities; the Area Health Resource File, and U.S. Census data.

Note: Boldface indicates statistical significance (***$p<0.001$; **$p<0.01$; *$p<0.05$). A multilevel/hierarchical model was employed to examine whether LHDs' active provision of mental health preventive care and health promotion can reduce the rates of preventable hospitalizations. Depression/anxiety is a subset of mental and substance use disorder. Specific ICD-9 codes used to measure specific mental illness are included in Appendix Table 2 (available online). Contextual factors include income in patients' residential ZIP-code, whether the LHD was in an urban or rural area, the percentage of the population residing in a county that report African American ancestry, the percentage of county population without high school degrees, and percentage of county population with insurance. Also included are measures indicating availability of mental healthcare resources: the number of community mental health centers, the number of federally qualified health centers, the number of primary care doctors and physicians specializing in mental health care, whether LHD had one or more local boards of health, the total full-time equivalents workforce at LHD, etc. These variables have been identified in the literature as predictors for healthcare utilization for people with mental illness. Contextual factors with significant coefficients are reported above.

ACSCs, ambulatory care sensitive conditions; LHD, local health department.

Table 3. Decomposition Estimation of the Contribution of LHDs to Reduce Racial Disparities in Preventable Hospitalizations

Decomposition results	Individuals with ACSCs + mental and substance use disorder	Individuals with ACSCs + depression/anxiety
Predicted probability of preventable hospitalizations (%)		
White	3.24	2.87
African American	4.98	4.43
Difference	**1.75*****	**1.56*****
Explained differences (%)	71.72	68.90
Explained by differences in LHDs' mental health preventive care (%)	**8.91*****	**8.61*****

Source: The linked data sets of the 2012–2013 Health Cost and Utilization Project (HCUP) State Inpatient Databases of the State of Maryland, the National Association of County and City Health Officials Profiles Survey (NACCHO), the American Hospital Directory, the National Directory of Mental Health Treatment Facilities; the Area Health Resource File, and U.S. Census data.
Note: Boldface indicates statistical significance (*$p<0.05$; **$p<0.01$; ***$p<0.001$). The Blinder–Oaxaca decomposition methods are used to estimate the racial disparities. Depression/anxiety is a subset of mental and substance use disorder. Specific ICD-9 codes used to measure specific mental illness are included in Appendix Table 2 (available online).
ACSCs, ambulatory care–sensitive conditions; LHD, local health department.

preventable hospitalizations were significantly higher among African Americans when compared with whites. The estimates are robust to different model specifications. Marginal estimates showed that direct provision of mental health preventive care by LHDs can reduce ≅5 admissions per 1,000 hospital admissions in total (which is ≅7% of preventable hospitalizations); and active provision of health promotion programs can also reduce 4–5 admissions per 1,000 hospital admissions in total (results not shown but are available upon request).

Decomposition results (Table 3) estimate that the rates of having a preventable ACSC with coexisting mental disorders ranged from 3.24% among whites, to 4.98% among African Americans; the rates of having a preventable ACSC with coexisting depression and anxiety was 2.87% among whites, and 4.43% among African Americans. The model explained 69%–72% of the differences across races. LHDs' mental health preventive care explained 9% of the observed differences in rates of having a preventable ACSC with coexisting mental disorders among white and African American patients.

DISCUSSION

This study showed that LHDs' provision of mental health preventive care and health promotion activities were significantly associated with lower rates of inpatient admissions for individuals with ACSCs and coexisting mental disorders. African Americans, however, were less likely than whites to live in the counties with LHDs that were active in the provision of mental health preventive care. By removing this disparity in access, LHDs' provision of mental health preventive care can potentially reduce approximately 9% of the observed racial disparities in hospitalization for ACSCs for individuals with mental illness and existing chronic diseases, such as heart disease and diabetes.

These findings suggest that LHDs' provision of mental health preventive care is expected to be effective, especially for vulnerable populations. Ongoing financial support for LHDs is warranted to maintain or expand activities in order to reduce disparities.[39] Minority patients face substantial barriers to receiving mental health care because of lack of access and stigma. Although this study did not examine stigma specifically, the authors speculated that the LHDs can serve as a mechanism to provide mental health care and health promotion and engage residents in wellness and treatment, especially for racial and ethnic minority populations. Recent research suggests that partnerships between hospital systems and public health departments can address some of the root causes of poor health by improving healthcare access, reducing social stigma, and reducing health disparities.[52,53] Because LHDs assume more responsibilities in underserved areas and provide a major source of health care for vulnerable populations, racial minority patients with mental disorders may gain more benefit from the effective LHD strategies identified by this study.

Awareness of mental health as a community health issue has emerged across public health leaders' agendas. The National Institutes of Mental Health identified strengthening the public health impact of their research and population approaches to treatment as priorities within their strategic plan.[54] The Robert Wood Johnson Foundation, through their Culture of Health Initiative, has implemented an approach to healthy communities that encompasses the full spectrum of physical, mental, and

social wellness. As advocated by the Substance Abuse and Mental Health Services Administration, integration of care not only improves access to mental health, but also improves general health care access for people with mental disorders.[8] Findings of this study are consistent with the literature on mental health integration models proposed by Substance Abuse Mental Health Services Administration and the strategic objective of the National Institute of Mental Health, to strengthen the public heath impact.[54] Results of this study can guide policy decision makers in federal, state, and local governments with critical information to evaluate LHDs' roles as essential components of care integration to improve mental health.

Limitations

This study has several limitations. First, this study focused on two domains of LHDs' activities using the binary measures given the data limitations. Possible variation in LHDs' level of effort to promote mental health was not captured in this analysis. To develop more informative policy implications, future studies should further examine the implementation quality of LHDs' activities. Second, the present analyses were limited to Maryland data, limiting the generalizability of the findings. Because LHD activities vary from state to state, more research is needed to understand whether LHDs across the U.S. are able to impact mental health in the same pattern. Any such comparison would need to control for differences in state payment models in addition to the numerous socioeconomic factors that were considered in this model. Third, despite controlling for a wide range of individual and community characteristics, some confounding variables might have been omitted because of data limitations. Lastly, using a cross-sectional design, this study examined the association between LHDs' activities and preventable hospitalizations. The study design and decomposition method do not allow for the investigation of causal mechanisms, for example, through feedback loops in which an increasing hospitalization rate prompts LHD action in response. Future studies should focus on the estimation of causality using longitudinal data sets. Despite these limitations, the results of this study provide the first evidence needed to develop a scientifically sound and culturally tailored public health–integrated healthcare model that will improve the efficiency of the healthcare delivery system and eliminate health disparities for individuals with mental disorders.

CONCLUSIONS

Improving care coordination and integration are essential to meet the growing demand for mental health care access, while controlling costs and improving the quality of service delivery. Results suggest that it will be cost effective, from a societal perspective, to engage LHDs as a component of an integrated behavioral health system. Future studies will be needed to investigate LHDs' roles in other states and to generalize these findings. Such studies will help researchers and policymakers understand the extent to which the resources of LHDs can be used or should be expanded to improve mental health and reduce racial disparities.

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SUPPLEMENTAL MATERIAL

Supplemental materials associated with this article can be found in the online version at https://doi.org/10.1016/j.amepre.2017.10.011.

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From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 6 Apr 2018 14:38:20 +0000
To: John Draper;McKeon, Richard (SAMHSA/CMHS);Pearson, Jane L (NIH/NIMH) [E]
Subject: RE: **Request for your review: Suicide Vital Signs Fact Sheet

Thank you very much, John. I look forward to reviewing your suggestions!
Deb

From: John Draper
Sent: Friday, April 6, 2018 10:30 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; McKeon, Richard (SAMHSA/CMHS) ; Pearson, Jane L (NIH/NIMH) [E]
Subject: Re: **Request for your review: Suicide Vital Signs Fact Sheet

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John Draper, Ph.D.
MHA-NYC
Project Director
National Suicide Prevention Lifeline | 1-800-273-TALK (8255)
and
Executive Vice President of National Networks
MHA-NYC
T: (212) 614-6309
T: (212) 614-6357
suicidepreventionlifeline.org |nfllifeline.org | Twitter | Facebook
Together, we can use our voices to help save lives.
Join us for our 26th Annual Gala on June 19, 2018.

From: Deborah Stone <zaf9@cdc.gov>
Date: Thursday, April 5, 2018 at 12:49 PM
To: MPH Richard McKeon <Richard.McKeon@samhsa.hhs.gov>, "jpearson@mail.nih.gov" <jpearson@mail.nih.gov>, "JohnD@mhaofnyc.org" <JohnD@mhaofnyc.org>
Subject: **Request for your review: Suicide Vital Signs Fact Sheet

Reminder: Think before you click! This email is from an external source and may include links or attachments. If it looks suspicious, don't click; forward to helpdesk@mhaofnyc.org.

Hi Richard, Jane, and John,
I hope you are doing well! As you are hopefully aware, CDC is releasing a Vital Signs on Suicide on June 5th. If you aren't familiar with *Vital Signs*, it began in 2010 and is a high profile monthly CDC publication widely distributed to highlight important public health threats and what can be done to prevent them. The release always includes a web page, an MMWR article, a translation piece (i.e. fact sheet), a press release, a telebriefing with the media by the CDC Director, a virtual town hall meeting, and other products. As you can imagine it's a lot of work! I am currently leading the effort but am assisted by many people.
I wanted to give you a heads-up about the content to make sure it strikes the right balance between highlighting the importance of mental health problems and the fact that many people don't have mental health problems so we need to address the range of risk and include a range of prev strategies. The

MMWR and the fact sheet are currently in clearance but we have a small window to make revisions. I have permission to share the fact sheet and some brief pieces of the MiMWR.
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MMWR Abstract

Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
Deb Stone, Tom Simon, Katie Fowler, Scott Kegler, Keming Yuan, Kristin Holland, Asha Ivey-Stephenson, and Alex Crosby

Background: Suicide rates in the United States have risen nearly 30% since 1999. Mental health problems (MHP) are just one factor contributing to suicide. Examining state-level trends in, and the multiple contributing circumstances to, suicide can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among people aged ≥10 years, by state and sex, across six consecutive three-year periods (1999-2016), were assessed using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health problems (MHP).

Results: From 1999-2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases of more than 30%...In 2015, more than half (54%) of decedents in 27 states did not have a known MHP. Among people with circumstance information, several circumstances, including relationship problems/loss (45.1% vs 39.6%), life stressors (54.2% vs 49.7%), and recent/impending crises (32.9% vs 26.0%) were significantly more likely among those without a known MHP than decedents with MHP, but were common across groups.

Conclusions: Suicide rates increased significantly across most states from 1999-2016. Various circumstances contributed to suicides among people with and without known MHP.

Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support people at risk, prevent reattempts, and help friends/family after a suicide occurs.

Part of the Intro (Would like your thoughts on whether this is striking the right balance. This is my main reason for wanting your feedback. We want to make the case for a focus on the full range of factors impacting on suicide and the full range of prevention strategies without inadvertently sending the message that those other factors and other strategies aren't important. They definitely are. We need it all.

- The *National Strategy for Suicide Prevention(NSSP)*(5) calls for a public health approach to suicide prevention with efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal). Such an approach underscores that suicide is rarely caused by any single factor, but rather, is multi-determined.
- Despite the NSSP guidance, suicide prevention efforts are largely clinically-oriented, focused on treating mental health problems (MHP) and preventing re-attempts (6).
- Apart from MHP and prior attempts, other contributing circumstances to suicide include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, and poor coping and problem-solving skills (5). Expanded awareness of these

additional circumstances contributing to suicide risk and action to address them, can help reach the nation's goal of reducing suicide rates 20% by 2025 (7).

Part of the methods:

- Characteristics and circumstances of suicide decedents ≥10 years old, with and without known MHP, were compared in the 27 states with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015.
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Part of the results: [Main point: while there were specific differences between the groups, the main point is that both groups had multiple circumstances and so we need to be addressing all of these in our prevention activities]

- People without known MHP were less likely to have any substance abuse problems
- ...two-thirds of those with known MHP had a history of mental health or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment.
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- Among all people with crises, intimate partner problems were the most common types and did not differ by group.
- Similarly, among people without versus with MHP, physical health problems and job/financial problems were commonly experienced and did not differ by group.

Part of the discussion:

- ...Additional research into the specific causes of these trends is necessary. Fortunately, data from the 27 states participating in NVDRS provides important insight into suicide circumstances and can help states identify prevention priorities.
- ...suicide prevention research and practice is heavily oriented towards downstream treatment of MHP and prevention of reattempts. Additional focus on non-mental health factors, further upstream, is essential to a public health approach (10), as the current study found that more than half of suicide decedents in NVDRS did *not* have a known MHP. ..
- ...people with MHP also experienced other life stressors such as job/financial, relationship, and/or physical health problems. These findings point to the need to both prevent the conditions associated with mental health problems in the first place, and to support people with known MHP to decrease their risk of poor outcomes.
- Two-thirds of this group had a history of any mental health and/or substance abuse treatment, with over half in treatment when they died. This suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to behavioral health providers in underserved areas is needed, as is expansion of healthcare systems needed that integrates physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions (12).
- Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide...[insert technical package components here]
- Limitation--abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can impact data completeness and

accuracy. Studies including more in-depth interviews with next-of-kin often see greater attributions to mental disorders.

From: John Draper
Sent: 6 Apr 2018 14:29:30 +0000
To: Stone, Deborah (CDC/ONDIEH/NCIPC);McKeon, Richard (SAMHSA/CMHS);Pearson, Jane L (NIH/NIMH) [E]
Subject: Re: **Request for your review: Suicide Vital Signs Fact Sheet
Attachments: Suicide Vital Signs Fact Sheet after roundtable to share 4.4.18[JD changes).docx

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From: Deborah Stone
Date: Thursday, April 5, 2018 at 12:49 PM
To: MPH Richard McKeon , "jpearson@mail.nih.gov" , "JohnD@mhaofnyc.org"
Subject: **Request for your review: Suicide Vital Signs Fact Sheet

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Rising suicide rates across states

More than just a mental health problem

45,000

Nearly 45,000 suicides in 2016

30%

Suicide rates increased more than 30% in half of states in the US

50%

More than half of people who died by suicide did not have a known mental health problem

Suicide is a leading cause of death in the US and has greatly increased in 44 states (1999-2016). Mental health problems are often seen as the sole cause, but suicide is rarely caused by a single factor. Many people who die by suicide are not known to have mental health problems at the time of death. Other issues also contribute to suicide, including failing relationships, poor health, job stress or unemployment, money, housing, and legal problems.

While suicide rates are climbing, suicide prevention is occurring every day. Survey data indicate that for every person who dies by suicide annually, approximately 280 persons think serviouly about suicide but do not kill themselves, and nearly 60 others survive a suicide attempt, the overwhelming majority of which go on to live out their lives. Persons who have been suicidal cite a number of behaviors that keep them safe, ranging from engaging social and spiritual supports to mental health service supports, and practicing positive coping skills. Close coordination of civic, law enforcement, business, education, social services, faith, media, and health sectors is important for preventing suicide. Individuals, Sstates and communities can take actions now based on the best available evidence. State public health departments can be the leaders in bringing together the necessary community partners to promote individual and collective ~~for~~ actions to prevent suicide.

Individuals concerned about persons who could be suicidal can:

- **Ask them directly if they are thinking about suicide**
- **Keep them safe by removing access to means for killing themselves**
- **Be there for them, listening non-judgmentally, letting them know you care about them**
- **Help them connect with others who can support them through this painful time**
- **Follow up with them to let them know that you are there for them**

For more information, see Bethe1to.com

States and communities can:

- Identify and support people at risk of suicide.

Comment [Office]: Ratios taken from data compiled from federal surveys of both youth and adults:
Source: * National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Available from: www.cdc.gov/injury/wisqars/index.html **. And CDC YRBS, 2016**
**Substance Abuse and Mental Health Services Administration, *Results from the 2015 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-42, HHS Publication No. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. And CDC YRBS, 2016.

Comment [Office]: Owens D, Horrocks J, and House A. Fatal and non-fatal repetition of self-harm: systematic review. British Journal of Psychiatry. 2002;181:193-199.

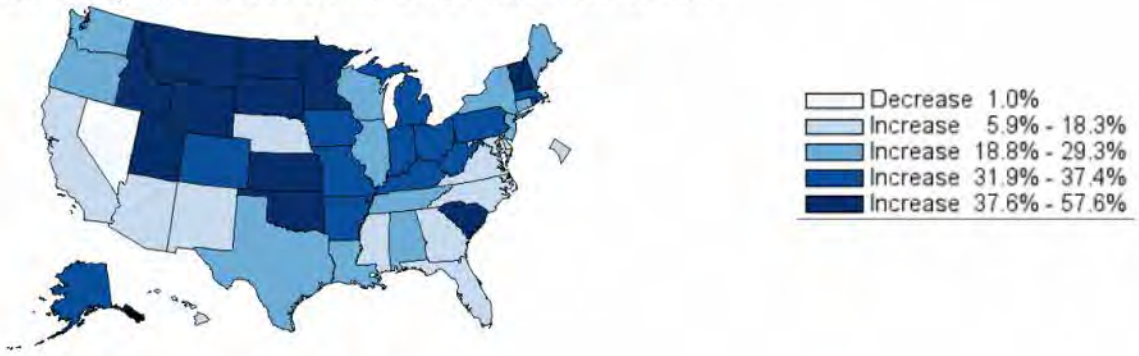
Comment [Office]: See Alexander et al 2009: https://ps.psychiatryonline.org/doi/full/10.1176/ps.2009.60.9.1214

- Lessen harms and prevent future risk of suicide.
- Teach coping and problem-solving skills to help youth and adults manage everyday challenges.
- Create safe and supportive environments where people live, work, learn, and play.
- Make sure people are connected to others in their community and don't feel alone.
- Make sure those at risk are connected to healthcare systems that include mental and physical health.
- Strengthen temporary financial and housing assistance for those struggling to make ends meet.

[INCLUDE LINK TO TECHNICAL PACKAGE: www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf]

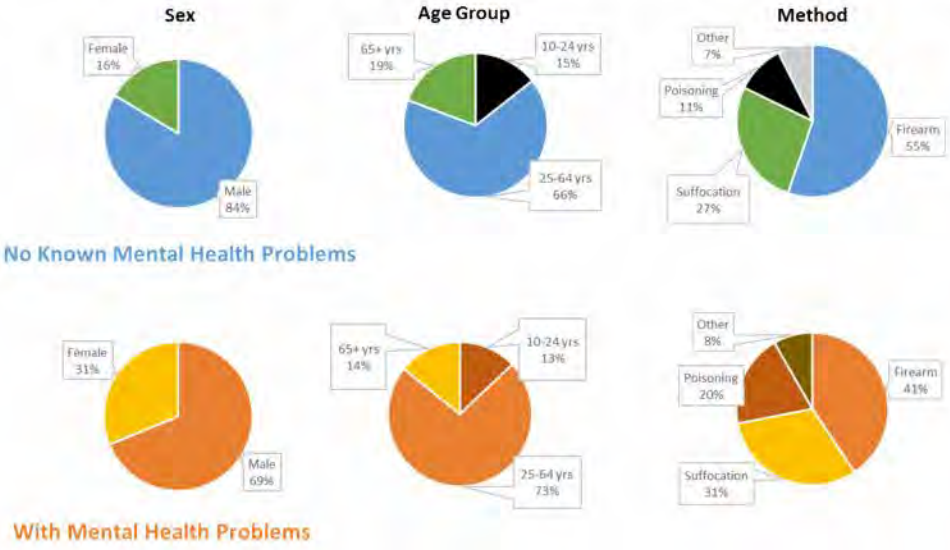
Problem: State suicide rate increases ranged from 6% to 58%

Deaths by suicide rose across the US from 1999 to 2016



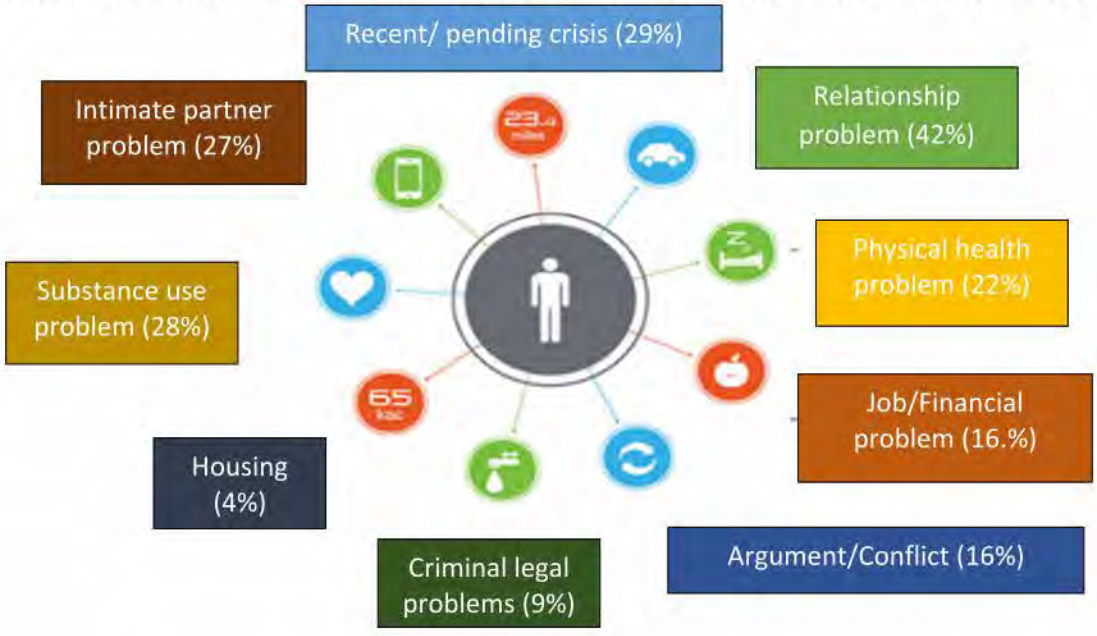
Many factors contribute to suicide

- 54% of people who died by suicide did not have a known mental health problem.



- Many factors contribute to suicide among those with and without mental health problems.

[Note: Icons below will be changed to reflect the problem listed. This is just to convey the idea]



States are seeing increases. What can they do prevent suicides?

Use *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* to make decisions based on the best evidence for suicide prevention **[This could be in a banner going across the page with the link to the technical package www.cdc.gov/violenceprevention/pub/technical-packages.html]**



[Create an infographic like the one below that lists warning signs. It will be updated to reflect the latest guidance on warning signs]



WHAT CAN BE DONE



The Federal government is:

- Tracking and monitoring the problem.
- Sharing information on actions proven to prevent suicide.
- Working with other local, state, and federal governmental agencies to prevent suicide.

States and communities can:

- Identify and support people at risk of suicide.
- Lessen harms and prevent future risk of suicide.
- Teach coping and problem-solving skills to help youth and adults manage everyday challenges.
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- Make sure people are connected to others in their community and don't feel alone.
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Healthcare systems can

- Make sure entire healthcare systems provide high quality, ongoing care, focusing on suicide prevention.
- Make sure healthcare is easily accessible and provide options such as telecommunications in areas where services aren't available.
- Provide personalized, proven treatment plans for patients at risk of suicide.

Employers can:

- Promote employee health and well-being, support people at risk, and have plans in place to respond to risk effectively.
- Train all employees about suicide risk and prevention.
- Encourage employees to seek help and provide referrals to mental health, substance abuse, or financial counseling services as needed.

Everyone can:

- Reduce access to lethal means, such as medications and firerams, among people at risk.
- Learn the warning signs of suicide to help identify and refer people at risk.
- Contact the National Suicide Prevention Lifeline for help for themselves or others: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org/

[Call out box: The media can encourage help-seeking and avoid dramatic headlines using guidelines at www.ReportingOnSuicide.org]

Comment [Office]: These steps are fine, but I would consider combining them with repeating the steps and info found on the Lifeline's Bethe1to.com

From: Pearson, Jane L (NIH/NIMH) [E]
Sent: 5 Apr 2018 20:46:04 +0000
To: McKeon, Richard (SAMHSA/CMHS);Stone, Deborah (CDC/ONDIEH/NCIPC);John Draper
Subject: RE: **Request for your review: Suicide Vital Signs Fact Sheet

Hi Deb,
Thanks for the opportunity
Will try to meet your deadline
Jane

From: McKeon, Richard (SAMHSA/CMHS)
Sent: Thursday, April 5, 2018 2:31 PM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Pearson, Jane L (NIH/NIMH) [E] ; John Draper
Subject: Re: **Request for your review: Suicide Vital Signs Fact Sheet

Will take a look. Thanks for the opportunity

On: 05 April 2018 12:51,
"Stone, Deborah (CDC/ONDIEH/NCIPC)" <zaf9@cdc.gov> wrote:

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Methods: Trends in age-adjusted suicide rates among people aged ≥10 years, by state and sex, across six consecutive three-year periods (1999-2016), were assessed using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health problems (MHP).
Results: From 1999-2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases of more than 30%...In 2015, more than half (54%) of decedents in 27 states did not have a known MHP. Among people with circumstance information, several circumstances, including relationship problems/loss (45.1% vs 39.6%), life stressors (54.2% vs 49.7%), and recent/impending crises (32.9% vs 26.0%) were significantly more likely among those without a known MHP than decedents with MHP, but were common across groups.
Conclusions: Suicide rates increased significantly across most states from 1999-2016. Various circumstances contributed to suicides among people with and without known MHP.
Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support people at risk, prevent reattempts, and help friends/family after a suicide occurs.

Part of the Intro (Would like your thoughts on whether this is striking the right balance. This is my main reason for wanting your feedback. We want to make the case for a focus on the full range of factors impacting on suicide and the full range of prevention strategies without inadvertently sending the message that those other factors and other strategies aren't important. They definitely are. We need it all.

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- Despite the NSSP guidance, suicide prevention efforts are largely clinically-oriented, focused on treating mental health problems (MHP) and preventing re-attempts (6).
- Apart from MHP and prior attempts, other contributing circumstances to suicide include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, and poor coping and problem-solving skills (5). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them, can help reach the nation's goal of reducing suicide rates 20% by 2025 (7).

Part of the methods:

- Characteristics and circumstances of suicide decedents ≥10 years old, with and without known MHP, were compared in the 27 states with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015.
- NVDRS defines MHP as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (9), with the exception of alcohol and other substance dependence, which are captured separately in NVDRS.

Part of the results: [Main point: while there were specific differences between the groups, the main point is that both groups had multiple circumstances and so we need to be addressing all of these in our prevention activities]

- People without known MHP were less likely to have any substance abuse problems
- ...two-thirds of those with known MHP had a history of mental health or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment.

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- Among all people with crises, intimate partner problems were the most common types and did not differ by group.
- Similarly, among people without versus with MHP, physical health problems and job/financial problems were commonly experienced and did not differ by group.

Part of the discussion:

- ...Additional research into the specific causes of these trends is necessary. Fortunately, data from the 27 states participating in NVDRS provides important insight into suicide circumstances and can help states identify prevention priorities.
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- ...people with MHP also experienced other life stressors such as job/financial, relationship, and/or physical health problems. These findings point to the need to both prevent the conditions associated with mental health problems in the first place, and to support people with known MHP to decrease their risk of poor outcomes.
- Two-thirds of this group had a history of any mental health and/or substance abuse treatment, with over half in treatment when they died. This suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to behavioral health providers in underserved areas is needed, as is expansion of healthcare systems needed that integrates physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions (12).
- Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide...[insert technical package components here]
- Limitation--abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can impact data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often see greater attributions to mental disorders.

From: John Draper
Sent: 5 Apr 2018 19:10:01 +0000
To: McKeon, Richard (SAMHSA/CMHS)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC);Pearson, Jane L (NIH/NIMH) [E]
Subject: Re: **Request for your review: Suicide Vital Signs Fact Sheet

Thanks Deb. Will review and get back to you....

Sent from my iPhone

On Apr 5, 2018, at 2:31 PM, McKeon, Richard (SAMHSA/CMHS) <Richard.McKeon@samhsa.hhs.gov> wrote:

> Will take a look. Thanks for the opportunity
>
> ---
>
> On: 05 April 2018 12:51,
> "Stone, Deborah (CDC/ONDIEH/NCIPC)" <zaf9@cdc.gov> wrote:
>
> Hi Richard, Jane, and John,
> I hope you are doing well! As you are hopefully aware, CDC is releasing a Vital Signs on Suicide on June 5th. If you aren't familiar with *Vital Signs*, it began in 2010 and is a high profile monthly CDC publication widely distributed to highlight important public health threats and what can be done to prevent them. The release always includes a web page, an MMWR article, a translation piece (i.e. fact sheet), a press release, a telebriefing with the media by the CDC Director, a virtual town hall meeting, and other products. As you can imagine it's a lot of work! I am currently leading the effort but am assisted by many people.
> I wanted to give you a heads-up about the content to make sure it strikes the right balance between highlighting the importance of mental health problems and the fact that many people don't have mental health problems so we need to address the range of risk and include a range of prev strategies. The MMWR and the fact sheet are currently in clearance but we have a small window to make revisions. I have permission to share the fact sheet and some brief pieces of the MiMWR.
> Wondering if you can respond by Monday noon with any comments on the fact sheet and any tweaks to wording in text below if you think it's not in balance. Also note that certain details have been omitted (some of which are actually in the fact sheet).
> A note on the fact sheet: This draft is the result of our first (3 hr meeting) with the vital signs team. We've been told the fact sheet goes through like 200 revisions?! Everything in the fact sheet must also be stated in the MMWR and it has to be plain language. The fact sheet is 4 pages and came with 14 pages of guidance if that tells you anything! Attaching the latest opioid one for your convenience.
> **MMWR Abstract**

Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates

Deb Stone, Tom Simon, Katie Fowler, Scott Kegler, Keming Yuan, Kristin Holland, Asha Ivey-Stephenson, and Alex Crosby

Background: Suicide rates in the United States have risen nearly 30% since 1999. Mental health problems (MHP) are just one factor contributing to suicide. Examining state-level trends in, and the multiple contributing circumstances to, suicide can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among people aged ≥10 years, by state and sex, across six consecutive three-year periods (1999-2016), were assessed using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health problems (MHP).

Results: From 1999-2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases of more than 30%...In 2015, more than half (54%) of decedents in 27 states did not have a known MHP. Among people with circumstance information, several circumstances, including relationship problems/loss (45.1% vs 39.6%), life stressors (54.2% vs 49.7%), and recent/impending crises (32.9% vs 26.0%) were significantly more likely among those without a known MHP than decedents with MHP, but were common across groups.

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Part of the results: [Main point: while there were specific differences between the groups, the main point is that both groups had multiple circumstances and so we need to be addressing all of these in our prevention activities]

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Part of the discussion:

- ...Additional research into the specific causes of these trends is necessary. Fortunately, data from the 27 states participating in NVDRS provides important insight into suicide circumstances and can help states identify prevention priorities.
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From: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Sent: 25 Apr 2018 08:42:21 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Subject: RE: **VS Updates** - date for pre-brief

Greetings:
Just 1 comment to start. I have the pre-brief scheduled for 8 May @ 1:00 instead of the 7th. Which one is correct?
Alex C

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 25, 2018 12:15 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD)
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) ; Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
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Crystal to Marie, myself, Malia, Tom, and will be reviewed in the next day by Leslie. These items are due to the VS office this Friday, April 27th. I'm working on some FAQs today to include with the telebriefing script.

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That's all for now. Sorry for the overly long email. Please let me know if you have any questions or concerns. Thanks a million to everyone for the great work. We've really made great strides thus far! Six week to go. Go Team! ☺

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Deb Stone, ScD, MSW, MPH
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Division of Violence Prevention
Suicide, Youth Violence & Elder Maltreatment Team
770.488.3942
dstone3@cdc.gov

CDC's Injury Center
Preventing Injuries and Violence Through Science and Action

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 25 Apr 2018 13:56:14 +0000
To: Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Subject: RE: **VS Updates** - pictures

Thanks, Alex. I'm deferring to Molly and Crystal at this point! Nothing seems to be hitting the mark for me. I may need to relent on no head in hands, no depressing pictures, ha!
Deb

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Sent: Wednesday, April 25, 2018 8:47 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Yuan, Keming (CDC/ONDIEH/NCIPC) ; Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) ; Holland, Kristin (CDC/ONDIEH/NCIPC) ; Ballman, Marie R. (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD)
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Subject: RE: **VS Updates** - pictures
Attachments: NSDUH MMWR cover Oct 2011.pdf

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Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Surveillance Summaries / Vol. 60 / No. 13
October 21, 2011

Suicidal Thoughts and Behaviors Among Adults Aged ≥18 Years — United States, 2008–2009



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 26 Apr 2018 13:38:14 +0000
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: **VS Updates**

Great, thank you!!
Deb

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Thursday, April 26, 2018 8:47 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC)
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: **VS Updates**

Hi Deb-
Thanks for the contact info on the SAVE and National Council for Suicide Prevention, we'll reach out to Dan ASAP.
We're talking to the Surgeon General's office today so hopefully will have more info on how he'll be involved that I can share soon.
Malia

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 25, 2018 10:07 PM
To: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>
Cc: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: **VS Updates**

Hi Malia,
Thank you so much for the extensive update. I can't thank you enough for all that you are doing! So exciting!
Please let Tom and I know when you hear back from the Surgeon General's Office and let me know if I can be of help in any way as plans (hopefully) move forward.
Also, if it's not too late and if you haven't already done so, I suggest we connect with the National Council for Suicide Prevention led by Dan Reidenberg.
I was reminded of the group last week when I saw Dan at AAS. Colleen Carr at the Action Alliance also recommended he'd be important to bring into the loop re the VS. He could have some strong opinions so would be good to touch base with him to get him on board.
Also, as just a little back story, Dan has been trying to connect with us/CDC more (first through his suggestion for his program LEADS in the technical package which we had to tell him it didn't have enough evidence) and more recently through some of his work with the response to 13RW. Kristin and I were meeting with he and others around this for a while but then we both got super busy and haven't been engaged any longer. All this to say I don't want him to feel we've forgotten him or don't value his partnership.
Here's Dan's contact info (can't find his phone number right away)
Daniel J. Reidenberg, PsyD
Executive Director - Suicide Awareness Voices of Education
Managing Director - National Council for Suicide Prevention
Gen Secretary - International Association for Suicide Prevention
dreidenberg@save.org
Let me know if you have any questions or if you want to talk further.
Thanks!

Deb

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 25, 2018 9:11 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC) <bnb1@cdc.gov>; Herbst, Jeffrey (CDC/ONDIEH/NCIPC) <afo4@cdc.gov>
Subject: RE: **VS Updates**

Here's a update on partnership engagement

- Wrote talking points about the VS release in Dr. Schuchat's participating in AA EXCOM mtg and Robin Ikeada's remarks at AAS.
- Action Alliance
  - Erin had a call in February priming them for the release and discussing different ideas
  - Working on Co-hosted Twitter chat between Action Alliance and CDC Injury being planned
  - AA will promote release via AA and SPRC's social media and listserv channels
- AFSP
  - Erin and Kinzie had initial call with AFSP
  - AFSP wants to highlight VS findings at their annual policy summit (July 10-13)
  - Will disseminate through social media and use data for educational materials
  - Second call scheduled for next week
- Surgeon General
  - Reached out to SGO's office–still waiting for them to confirm he can participate in the launch on June7.
- DVP Policy Network – priming key partners at May 8th quarterly call
  - Will brainstorm ways to promote VS – social media, newsletters, webinars
  - Key partners: AAP, ASTHO, NACCHO, ASTHO, AFSP, Safe States, ACPM
- Working with NCSL to develop a blog post to be published in late June or July
- Hill outreach
  - IDing offices to send Hill Alerts, including Congressional Mental Health Caucus and Congressional Suicide Prevention Task Force
  - Drafting plan for additional outreach

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 25, 2018 12:15 AM
To: Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Yuan, Keming (CDC/ONDIEH/NCIPC) <vrm4@cdc.gov>; Kegler, Scott R. (CDC/ONDIEH/NCIPC) <snk6@cdc.gov>; Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC) <iym9@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Holland, Kristin (CDC/ONDIEH/NCIPC) <imh1@cdc.gov>; Ballman, Marie R. (CDC/ONDIEH/NCIPC) <dof3@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Kurnit, Molly Regina (CDC/ONDIEH/NCIPC) <uzu3@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>
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CDC's Injury Center
Preventing Injuries and Violence Through Science and Action

From: Kegler, Scott R. (CDC/ONDIEH/NCIPC)
Sent: 25 Apr 2018 17:31:23 -0400
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: **VS Updates**

I don't expect them to budge but the points are still worth making.

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: Wednesday, April 25, 2018 5:20 PM
To: Kegler, Scott R. (CDC/ONDIEH/NCIPC) ; Simon, Thomas (CDC/ONDIEH/NCIPC)
Subject: RE: **VS Updates**

Hi Scott,
Your comments have been included in today's submission of the graphic copy of the fact sheet.
Thanks as always for your attention to detail.
Deb

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Sent: Wednesday, April 25, 2018 9:44 AM
To: Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>
Subject: RE: **VS Updates**

Regarding the map in the mock-up:

- DC is not broken out and hence is not discernable.
- Is this really a standard color scheme? I'm partially (not completely) color blind and can't easily match the map colors to the map legend in this scheme. That's why I used a single-hue sequential scheme in my map – it's the depth of the color, not the hue, that matters in such a scheme. I suggest that the VS staff acquaint themselves with Color Brewer – free online software supported by Penn State University: http://colorbrewer2.org/#type=sequential&scheme=BuGn&n=3
- For this map, the scheme should almost certainly be sequential as nearly all entries are going in the same direction.

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From: Sokler, Lynn (CDC/OD/OADC)
Sent: 6 Jun 2018 16:20:22 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Lenard, Courtney (CDC/ONDIEH/NCIPC);Dorigo, Leslie (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Simon, Thomas (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Gaines-McCollom, Molly (CDC/OPHPR/DEO);DeNoon, Daniel (CDC/OD/OADC) (CTR);Grusich, Katherina (Kate) (CDC/OD/OADC);Hoskins, Sharon (K.D.) (CDC/OD/OADC);Iverson, Dontae (CDC/OD/OADC);Balluz, Lina (ATSDR/DTHHS/OD);Bonds, Michelle E. (CDC/OD/OADC);Brand, Anstice M. (CDC/OD/CDCWO);Brown, Renee (CDC/ONDIEH/NCCDPHP);Bumpus, Stefanie (CDC/OID/NCEZID);Burden, Bernadette (CDC/OD/OADC);Burns, Annina (CDC/OD/CDCWO);Charles, Julia (CDC/OD/OCS);Clark, Cynthia K. (CDC/OD/OCS);Crawford, Carol Y. (CDC/OD/OADC);Daniel, Katherine Lyon (CDC/OD/OADC);Das, Mansi S. (CDC/OD/OADC);Dempsey, Jay H. (CDC/OD/OADC);Diaz, Shelly S. (CDC/OID/NCHHSTP);Dills, Kimberly C. (ATSDR/OPPE);DPAID (CDC);Dunn, Evelyn (CDC/OCOO/OFR/OA);Galatas, Kate (CDC/OD/OADC);Gonzalez, Belsie (CDC/OD/OADC);Grant, Llelwyn (CDC/OD/OADC);Green, Hugh (CDC/OD/OCS);Guest, Megan (CDC/OD/OADC);Heldman, Amy B. (CDC/OD/OADC);Hogg, Jarrad (CDC/OD/OADC);Hoo, Elizabeth (CDC/OD/PPEO);Iademarco, Michael (CDC/OPHSS/CSELS/OD);Joyner, Tonya (CDC/OSTLTS/OD) (CTR);Kelly, Alison (CDC/OCOO/OFR/OA);Kent, Charlotte (CDC/OPHSS/CSELS/DPHID);Knight, Dianna (CDC/OD/OADC);Knotts, Ashley (CDC/OD/OCS);Kroop, Seth (CDC/OD/OCS);Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD);Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD);McGowan, Robert (Kyle) (CDC/OD/OCS);Olivares, Dagny (CDC/OSTLTS/OD);Parikh, Sapana (CDC/OCOO/OFR/OA);Parker, Stacey M. (CDC/OSTLTS/OD) (CTR);Payne, Chelsea C. (CDC/OSTLTS/OD);Putman, Ami D. (CDC/OPHSS/CSELS/DLS);Rasmussen, Sonja (CDC/OID/OD);Redd, Stephen (CDC/OPHPR/OD);Redfield, Robert R. (CDC/OD);Schattner, Aimee (CDC/OD/CDCWO);Schindelar, Jessica (CDC/OD/OADC);Schuchat, Anne MD (CDC/OD);Simon, Gia M. (CDC/OSTLTS/OD);Smith, Patti (CDC/OD/OADC);Sorrells, Marjorie J. (CDC/OD/OCS);Stanojevich, Joel G. (CDC/CGH/OD);Ware, Nina (CDC/OD/OADS);Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID);Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR);Wilson, Michelle (CDC/OCOO/OFR/OA)
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID);Peaker, Brandy (CDC/OPHSS/CSELS/DPHID);Omisore, Shannon L. (CDC/OD/OADC);Turner, Cheryl L. (CDC/OD/OADC) (CTR);Guest, Megan (CDC/OD/OADC);McGuire, Delaney (CDC/OD/OADC);Roberts, Ursula (CDC/OD/OCS) (CTR)
Subject: Supplemental Table- FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention
Attachments: MMWR Supplemental table__VS Suicide_ 6.7.2018_final.pdf

Hi Folks,
Sending a table that will appear in the MMWR. For those of you distributing to others tomorrow morning, please include the table with the other materials.
Thanks, Lynn

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Wednesday, June 6, 2018 2:33 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) ; Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Dorigo, Leslie (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Simon, Thomas

(CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Gaines-McCollom, Molly (CDC/OPHPR/DEO) ; DeNoon, Daniel (CDC/OD/OADC) (CTR) ; Grusich, Katherina (Kate) (CDC/OD/OADC) ; Hoskins, Sharon (K.D.) (CDC/OD/OADC) ; Iverson, Dontae (CDC/OD/OADC) ; Balluz, Lina (ATSDR/DTHHS/OD) ; Bonds, Michelle E. (CDC/OD/OADC) ; Brand, Anstice M. (CDC/OD/CDCWO) ; Brown, Renee (CDC/ONDIEH/NCCDPHP) ; Bumpus, Stefanie (CDC/OID/NCEZID) ; Burden, Bernadette (CDC/OD/OADC) ; Burns, Annina (CDC/OD/CDCWO) ; Charles, Julia (CDC/OD/OCS) ; Clark, Cynthia K. (CDC/OD/OCS) ; Crawford, Carol Y. (CDC/OD/OADC) ; Daniel, Katherine Lyon (CDC/OD/OADC) ; Das, Mansi S. (CDC/OD/OADC) ; Dempsey, Jay H. (CDC/OD/OADC) ; Diaz, Shelly S. (CDC/OID/NCHHSTP) ; Dills, Kimberly C. (ATSDR/OPPE) ; DPAID (CDC) ; Dunn, Evelyn (CDC/OCOO/OFR/OA) ; Galatas, Kate (CDC/OD/OADC) ; Gonzalez, Belsie (CDC/OD/OADC) ; Grant, Llelwyn (CDC/OD/OADC) ; Green, Hugh (CDC/OD/OCS) ; Guest, Megan (CDC/OD/OADC) ; Heldman, Amy B. (CDC/OD/OADC) ; Hogg, Jarrad (CDC/OD/OADC) ; Hoo, Elizabeth (CDC/OD/PPEO) ; Iademarco, Michael (CDC/OPHSS/CSELS/OD) ; Joyner, Tonya (CDC/OSTLTS/OD) (CTR) ; Kelly, Alison (CDC/OCOO/OFR/OA) ; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) ; Knight, Dianna (CDC/OD/OADC) ; Knotts, Ashley (CDC/OD/OCS) ; Kroop, Seth (CDC/OD/OCS) ; Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD) ; Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD) ; McGowan, Robert (Kyle) (CDC/OD/OCS) ; Olivares, Dagny (CDC/OSTLTS/OD) ; Parikh, Sapana (CDC/OCOO/OFR/OA) ; Parker, Stacey M. (CDC/OSTLTS/OD) (CTR) ; Payne, Chelsea C. (CDC/OSTLTS/OD) ; Putman, Ami D. (CDC/OPHSS/CSELS/DLS) ; Rasmussen, Sonja (CDC/OID/OD) ; Redd, Stephen (CDC/OPHPR/OD) ; Redfield, Robert R. (CDC/OD) ; Schattner, Aimee (CDC/OD/CDCWO) ; Schindelar, Jessica (CDC/OD/OADC) ; Schuchat, Anne MD (CDC/OD) ; Simon, Gia M. (CDC/OSTLTS/OD) ; Smith, Patti (CDC/OD/OADC) ; Sokler, Lynn (CDC/OD/OADC) ; Sorrells, Marjorie J. (CDC/OD/OCS) ; Stanojevich, Joel G. (CDC/CGH/OD) ; Ware, Nina (CDC/OD/OADS) ; Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID) ; Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR) ; Wilson, Michelle (CDC/OCOO/OFR/OA)

Cc: Sokler, Lynn (CDC/OD/OADC) ; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) ; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) ; Omisore, Shannon L. (CDC/OD/OADC) ; Turner, Cheryl L. (CDC/OD/OADC) (CTR) ; Guest, Megan (CDC/OD/OADC) ; McGuire, Delaney (CDC/OD/OADC) ; Roberts, Ursula (CDC/OD/OCS) (CTR)

Subject: FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention

Hi Folks,

This month's issue of Vital Signs is on **Suicide Rates Rising across the U.S.** and releases **Thursday, June 7** with a Media Telebriefing at noon. **All materials go live on the CDC website at 1 pm**. Here are the key materials to use to distribute to stakeholders and partners: The Dear Colleague letter, MMWR, Fact Sheet, Press Release and Graphic.

For those distributing to media, please send the MMWR, Fact Sheet, Press Release and Graphic. Dr. Schuchat will be the primary spokesperson for this Vital Signs.

For those of you distributing out to partners and other constituents Thursday morning at 9 am, please make sure they know these are advance copies only. These materials are **embargoed until Thursday June 7 at 1 pm**. Please adjust the Dear Colleague letter for those people to which you send. Also please send Rich and me a copy when you email this out to your groups.

We will also have the press release on CDC en Espanol and available through the Vital Signs website.

For those attending the media telebriefing, I have also attached the Telebriefing Script and the Q&A document. **These do not get distributed externally.**

For each Vital Signs issue, we track and report on results **two times** – after 24 hours and after 30 days. We track the number of audiences reached (from all media and web sources), # of stories and type of media, the dollar value of the media coverage if CDC had to purchase it as advertising, social media use and reuse, and # of people looking at Vital Signs on our web pages.

Vital Signs reaches out to a lot of different people with our topics and, from our evaluation surveys, the uptake out in the field is impressive. In a survey, an astounding **95%** of state health officers and state epidemiologists were aware of and used VS issues, with about 3 in 4 using VS in the past year. All shared the material with their constituents via conference call, e-mail, newsletter, or mailing for topics

appropriate to their members. A stratified random sample survey, used with NACCHO member organizations, reported that **74%** of all county or local health departments had heard of or used VS in the past year to educate staff, improve programs, and guide policy formation. As well, a 2017 internal evaluation showed that most program staff involved believe the value derived from it is worth the work, although producing Vital Signs takes a lot of effort.

I want to thank everyone who has worked on this issue for all their extra efforts. It's a very important topic and will be valuable information for many people. We hope that program continues to use this Vital Signs to promote its messages and the recommended actions in it to achieve new results.

Cheers,

Lynn

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Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
U.S.	Both	12.3 (n/a)	12.7 (+ 0.4)	12.9 (+ 0.2)	13.8 (+ 0.9)	14.5 (+ 0.8)	15.4 (+ 0.9)	+ 1.5 % (p<.01)	n/a	+ 3.1 (n/a)	+ 25.4 % (n/a)
	Male	20.9 (n/a)	21.2 (+ 0.4)	21.3 (+ 0.0)	22.5 (+1.3)	23.5 (+ 1.0)	24.5 (+ 1.0)	+ 1.1 % (p<.01)			
	Female	4.7 (n/a)	5.0 (+ 0.3)	5.3 (+ 0.2)	5.7 (+ 0.4)	6.2 (+ 0.5)	6.9 (+ 0.7)	+ 2.6 % (p<.01)			
AL	Both	14.3 (n/a)	13.4 (- 0.9)	14.1 (+ 0.6)	15.6 (+ 1.6)	16.4 (+ 0.7)	17.5 (+ 1.1)	+ 1.6 % (p<.05)	25	+ 3.1 (31)	+ 21.9 % (33)
	Male	25.1 (n/a)	23.4 (- 1.7)	24.4 (+ 1.0)	26.4 (+ 2.0)	27.6 (+ 1.1)	29.1 (+ 1.5)	+ 1.3 % (p<.05)			
	Female	5.1 (n/a)	4.8 (- 0.3)	5.0 (+ 0.2)	6.1 (+ 1.1)	6.4 (+ 0.3)	7.0 (+ 0.7)	+ 2.6 % (p<.01)			
AK	Both	21.0 (n/a)	24.8 (+ 3.8)	24.2 (- 0.6)	26.0 (+ 1.7)	25.4 (- 0.5)	28.8 (+ 3.4)	+ 1.7 % (p<.05)	2	+ 7.8 (4)	+ 37.4 % (13)
	Male	33.2 (n/a)	38.1 (+ 4.9)	38.9 (+ 0.8)	40.1 (+ 1.2)	40.1 (- 0.1)	42.9 (+ 2.8)	+ 1.4 % (p<.01)			
	Female	8.6 (n/a)	11.4 (+ 2.9)	9.8 (- 1.6)	11.1 (+ 1.2)	9.9 (- 1.2)	13.2 (+ 3.4)	+ 1.7 % n/s			
AZ	Both	17.8 (n/a)	18.5 (+ 0.7)	19.1 (+ 0.5)	19.1 (- 0.0)	20.4 (+ 1.3)	20.9 (+ 0.5)	+ 1.0 % (p<.01)	15	+ 3.1 (32)	+ 17.3 % (42)
	Male	29.3 (n/a)	30.2 (+ 1.0)	30.6 (+ 0.4)	30.2 (- 0.5)	32.0 (+ 1.9)	32.4 (+ 0.4)	+ 0.6 % (p<.05)			
	Female	7.1 (n/a)	7.5 (+ 0.4)	8.2 (+ 0.7)	8.6 (+ 0.5)	9.2 (+ 0.6)	9.9 (+ 0.6)	+ 2.2 % (p<.01)			
AR	Both	15.5 (n/a)	15.8 (+ 0.3)	16.2 (+ 0.5)	17.6 (+ 1.4)	19.2 (+ 1.6)	21.2 (+ 2.0)	+ 2.2 % (p<.01)	12	+ 5.7 (14)	+ 36.8 % (15)
	Male	26.7 (n/a)	26.7 (+ 0.0)	27.2 (+ 0.5)	28.2 (+ 1.0)	31.7 (+ 3.5)	33.5 (+ 1.9)	+ 1.6 % (p<.05)			
	Female	5.6 (n/a)	5.9 (+ 0.3)	6.2 (+ 0.4)	7.9 (+ 1.7)	7.5 (- 0.4)	9.6 (+ 2.1)	+ 3.6 % (p<.01)			
CA	Both	10.6 (n/a)	11.3 (+ 0.7)	11.0 (- 0.3)	12.0 (+ 1.0)	11.8 (- 0.1)	12.1 (+ 0.3)	+ 0.9 % (p<.05)	45	+ 1.6 (46)	+ 14.8 % (46)
	Male	17.9 (n/a)	18.4 (+ 0.5)	17.7 (- 0.7)	19.1 (+ 1.4)	18.9 (- 0.2)	19.2 (+ 0.3)	+ 0.5 % n/s			
	Female	4.1 (n/a)	5.0 (+ 0.9)	4.9 (- 0.1)	5.4 (+ 0.5)	5.3 (- 0.1)	5.6 (+ 0.3)	+ 1.7 % (p<.05)			
CO	Both	17.3 (n/a)	19.2 (+ 1.9)	19.0 (- 0.2)	20.0 (+ 1.0)	21.6 (+ 1.5)	23.2 (+ 1.6)	+ 1.8 % (p<.01)	8	+ 5.9 (12)	+ 34.1 % (22)
	Male	28.6 (n/a)	30.9 (+ 2.3)	30.5 (- 0.4)	31.5 (+ 1.0)	33.4 (+ 1.9)	36.3 (+ 2.9)	+ 1.4 % (p<.01)			
	Female	7.0 (n/a)	8.2 (+ 1.3)	8.2 (+ 0.0)	9.1 (+ 0.9)	10.1 (+ 1.0)	10.4 (+ 0.3)	+ 2.6 % (p<.01)			
CT	Both	9.6 (n/a)	8.9 (- 0.7)	9.1 (+ 0.2)	10.2 (+ 1.1)	11.0 (+ 0.8)	11.5 (+ 0.5)	+ 1.6 % (p<.05)	46	+ 1.9 (43)	+ 19.2 % (34)
	Male	16.4 (n/a)	14.6 (- 1.8)	15.0 (+ 0.4)	16.6 (+ 1.6)	17.6 (+ 1.0)	17.3 (- 0.3)	+ 0.9 % n/s			
	Female	3.6 (n/a)	3.8 (+ 0.2)	3.7 (- 0.2)	4.4 (+ 0.7)	4.9 (+ 0.5)	6.2 (+ 1.3)	+ 3.5 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
DE	Both	13.6 (n/a)	12.2 (- 1.4)	11.9 (- 0.3)	13.6 (+ 1.7)	14.2 (+ 0.6)	14.4 (+ 0.2)	+ 0.9 % n/s	42	+ 0.8 (50)	+ 5.9 % (50)
	Male	23.0 (n/a)	20.3 (- 2.7)	19.9 (- 0.4)	23.1 (+ 3.2)	22.7 (- 0.4)	23.5 (+ 0.8)	+ 0.6 % n/s			
	Female	5.3 (n/a)	5.0 (- 0.2)	4.6 (- 0.4)	4.9 (+ 0.3)	6.4 (+ 1.5)	6.2 (- 0.2)	+ 1.6 % n/s			
DC	Both	5.9 (n/a)	6.4 (+ 0.5)	6.4 (- 0.0)	7.3 (+ 0.8)	6.6 (- 0.7)	6.9 (+ 0.3)	+ 0.9 % n/s	51	+ 1.0 (48)	+ 16.1 % (45)
	Male	10.7 (n/a)	11.1 (+ 0.4)	10.3 (- 0.8)	12.7 (+ 2.4)	10.0 (- 2.6)	11.7 (+ 1.7)	+ 0.3 % n/s			
	Female	1.7 (n/a) ††	2.3 (+ 0.6) ††	3.3 (+ 1.0)	2.6 (- 0.7)	3.6 (+ 1.0)	2.8 (- 0.8)	+ 3.5 % n/s			
FL	Both	14.8 (n/a)	15.2 (+ 0.4)	14.9 (- 0.3)	16.3 (+ 1.4)	16.3 (- 0.0)	16.4 (+ 0.1)	+ 0.8 % (p<.05)	29	+ 1.6 (45)	+ 10.6 % (48)
	Male	24.3 (n/a)	24.4 (+ 0.1)	23.6 (- 0.8)	26.2 (+ 2.6)	25.6 (- 0.6)	25.6 (- 0.1)	+ 0.5 % n/s			
	Female	6.3 (n/a)	6.8 (+ 0.5)	6.8 (+ 0.0)	7.1 (+ 0.3)	7.6 (+ 0.5)	7.8 (+ 0.3)	+ 1.4 % (p<.01)			
GA	Both	12.9 (n/a)	13.2 (+ 0.3)	12.3 (- 0.9)	13.2 (+ 0.9)	13.7 (+ 0.5)	15.0 (+ 1.3)	+ 0.9 % n/s	39	+ 2.1 (40)	+ 16.2 % (44)
	Male	22.1 (n/a)	23.1 (+ 1.0)	21.3 (- 1.8)	21.9 (+ 0.6)	22.6 (+ 0.7)	24.4 (+ 1.7)	+ 0.5 % n/s			
	Female	5.0 (n/a)	4.8 (- 0.2)	4.6 (- 0.2)	5.5 (+ 0.9)	5.8 (+ 0.3)	6.6 (+ 0.8)	+ 2.1 % (p<.05)			
HI	Both	12.9 (n/a)	11.1 (- 1.8)	10.3 (- 0.7)	14.5 (+ 4.1)	14.4 (- 0.1)	15.2 (+ 0.8)	+ 2.0 % n/s	35	+ 2.4 (35)	+ 18.3 % (38)
	Male	20.4 (n/a)	17.2 (- 3.1)	15.3 (- 1.9)	21.9 (+ 6.7)	22.5 (+ 0.5)	24.3 (+ 1.8)	+ 2.1 % n/s			
	Female	5.4 (n/a)	5.0 (- 0.4)	5.5 (+ 0.5)	7.1 (+ 1.5)	6.2 (- 0.9)	5.9 (- 0.3)	+ 1.2 % n/s			
ID	Both	17.3 (n/a)	19.2 (+ 2.0)	18.3 (- 0.9)	21.6 (+ 3.3)	21.9 (+ 0.3)	24.7 (+ 2.8)	+ 2.3 % (p<.01)	6	+ 7.5 (6)	+ 43.2 % (7)
	Male	28.4 (n/a)	33.1 (+ 4.7)	31.1 (- 2.0)	34.9 (+ 3.8)	34.7 (- 0.2)	38.0 (+ 3.3)	+ 1.6 % (p<.05)			
	Female	7.2 (n/a)	6.1 (- 1.1)	6.1 (+ 0.0)	9.0 (+ 2.9)	9.5 (+ 0.5)	11.8 (+ 2.3)	+ 4.4 % (p<.05)			
IL	Both	9.9 (n/a)	9.8 (- 0.1)	9.7 (- 0.1)	10.6 (+ 0.8)	11.2 (+ 0.6)	12.2 (+ 1.0)	+ 1.5 % (p<.05)	44	+ 2.3 (38)	+ 22.8 % (32)
	Male	17.1 (n/a)	16.7 (- 0.4)	16.2 (- 0.4)	17.6 (+ 1.4)	18.5 (+ 0.9)	19.8 (+ 1.3)	+ 1.1 % (p<.05)			
	Female	3.7 (n/a)	3.6 (- 0.0)	3.8 (+ 0.2)	4.2 (+ 0.4)	4.5 (+ 0.4)	5.2 (+ 0.6)	+ 2.4 % (p<.01)			
IN	Both	13.0 (n/a)	13.7 (+ 0.7)	14.4 (+ 0.7)	14.9 (+ 0.5)	16.4 (+ 1.4)	17.1 (+ 0.7)	+ 1.9 % (p<.01)	26	+ 4.1 (23)	+ 31.9 % (25)
	Male	22.4 (n/a)	23.2 (+ 0.8)	24.4 (+ 1.2)	24.7 (+ 0.4)	26.7 (+ 2.0)	28.3 (+ 1.6)	+ 1.5 % (p<.01)			
	Female	4.6 (n/a)	5.0 (+ 0.4)	5.3 (+ 0.2)	5.9 (+ 0.6)	6.8 (+ 0.9)	6.6 (- 0.2)	+ 2.7 % (p<.01)			

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		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
IA	Both	11.8 (n/a)	13.2 (+ 1.4)	12.8 (- 0.4)	14.2 (+ 1.4)	15.9 (+ 1.7)	16.0 (+ 0.1)	+ 2.1 % (p<.01)	31	+ 4.3 (20)	+ 36.2 % (18)
	Male	20.6 (n/a)	22.1 (+ 1.5)	20.8 (- 1.4)	23.3 (+ 2.5)	26.0 (+ 2.7)	25.7 (- 0.3)	+ 1.6 % (p<.05)			
	Female	3.7 (n/a)	4.7 (+ 1.0)	5.3 (+ 0.6)	5.5 (+ 0.2)	6.1 (+ 0.6)	6.7 (+ 0.6)	+ 3.8 % (p<.01)			
KS	Both	13.3 (n/a)	15.1 (+ 1.8)	15.8 (+ 0.7)	15.3 (- 0.5)	17.7 (+ 2.4)	19.4 (+ 1.6)	+ 2.2 % (p<.01)	19	+ 6.0 (11)	+ 45.0 % (5)
	Male	22.7 (n/a)	25.0 (+ 2.3)	26.5 (+ 1.5)	25.6 (- 0.9)	29.1 (+ 3.5)	30.7 (+ 1.6)	+ 1.9 % (p<.01)			
	Female	4.6 (n/a)	6.0 (+ 1.4)	5.7 (- 0.3)	5.4 (- 0.3)	6.8 (+ 1.4)	8.4 (+ 1.6)	+ 3.2 % (p<.05)			
KY	Both	14.1 (n/a)	15.4 (+ 1.3)	16.7 (+ 1.3)	16.2 (- 0.5)	18.2 (+ 2.0)	19.3 (+ 1.1)	+ 1.9 % (p<.01)	20	+ 5.2 (16)	+ 36.6 % (16)
	Male	25.0 (n/a)	26.8 (+ 1.9)	28.3 (+ 1.4)	27.2 (- 1.0)	30.1 (+ 2.9)	31.7 (+ 1.6)	+ 1.4 % (p<.01)			
	Female	4.8 (n/a)	5.2 (+ 0.4)	6.1 (+ 0.8)	6.1 (+ 0.1)	7.1 (+ 0.9)	7.7 (+ 0.6)	+ 3.2 % (p<.01)			
LA	Both	13.1 (n/a)	12.9 (- 0.2)	13.4 (+ 0.4)	13.6 (+ 0.3)	14.4 (+ 0.8)	17.0 (+ 2.5)	+ 1.6 % (p<.05)	27	+ 3.8 (27)	+ 29.3 % (26)
	Male	22.9 (n/a)	22.3 (- 0.6)	22.4 (+ 0.1)	23.3 (+ 0.8)	23.7 (+ 0.5)	27.3 (+ 3.6)	+ 1.1 % n/s			
	Female	4.8 (n/a)	4.7 (- 0.1)	5.2 (+ 0.5)	4.9 (- 0.2)	6.1 (+ 1.2)	7.5 (+ 1.4)	+ 2.8 % (p<.05)			
ME	Both	14.5 (n/a)	13.6 (- 0.9)	14.4 (+ 0.8)	15.4 (+ 1.0)	18.9 (+ 3.5)	18.5 (- 0.4)	+ 2.2 % (p<.05)	21	+ 4.0 (25)	+ 27.4 % (29)
	Male	25.0 (n/a)	22.9 (- 2.1)	24.6 (+ 1.7)	25.7 (+ 1.1)	31.1 (+ 5.4)	29.8 (- 1.3)	+ 1.8 % (p<.05)			
	Female	5.3 (n/a)	5.3 (- 0.0)	5.2 (- 0.1)	6.0 (+ 0.7)	7.6 (+ 1.6)	7.9 (+ 0.3)	+ 3.1 % (p<.05)			
MD	Both	10.0 (n/a)	10.3 (+ 0.3)	10.1 (- 0.2)	10.2 (+ 0.1)	10.7 (+ 0.5)	10.8 (+ 0.1)	+ 0.5 % (p<.05)	47 §§	+ 0.8 (49 §§)	+ 8.5 % (49 §§)
	Male	17.6 (n/a)	17.8 (+ 0.1)	17.3 (- 0.5)	17.7 (+ 0.4)	18.2 (+ 0.5)	18.0 (- 0.2)	+ 0.2 % n/s			
	Female	3.5 (n/a)	3.8 (+ 0.4)	3.9 (+ 0.0)	3.7 (- 0.2)	4.1 (+ 0.4)	4.5 (+ 0.4)	+ 1.3 % (p<.05)			
MA	Both	7.4 (n/a)	7.6 (+ 0.2)	8.4 (+ 0.8)	9.3 (+ 1.0)	9.8 (+ 0.4)	10.0 (+ 0.3)	+ 2.3 % (p<.01)	48	+ 2.6 (34 ¶¶)	+ 35.3 % (20 ¶¶)
	Male	12.1 (n/a)	12.8 (+ 0.7)	13.3 (+ 0.5)	15.4 (+ 2.1)	15.2 (- 0.2)	16.0 (+ 0.8)	+ 2.0 % (p<.01)			
	Female	3.3 (n/a)	2.9 (- 0.4)	4.0 (+ 1.0)	3.8 (- 0.1)	4.8 (+ 1.0)	4.6 (- 0.2)	+ 3.0 % (p<.05)			
MI	Both	11.8 (n/a)	12.5 (+ 0.7)	12.9 (+ 0.4)	13.9 (+ 1.0)	14.5 (+ 0.7)	15.6 (+ 1.1)	+ 1.9 % (p<.01)	33	+ 3.9 (26)	+ 32.9 % (24)
	Male	20.0 (n/a)	20.9 (+ 0.9)	21.6 (+ 0.7)	22.8 (+ 1.3)	23.9 (+ 1.0)	25.0 (+ 1.2)	+ 1.5 % (p<.01)			
	Female	4.4 (n/a)	4.8 (+ 0.4)	5.0 (+ 0.2)	5.6 (+ 0.6)	5.9 (+ 0.3)	6.7 (+ 0.9)	+ 2.8 % (p<.01)			

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State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
MN	Both	10.7 (n/a)	11.5 (+ 0.9)	12.4 (+ 0.8)	12.9 (+ 0.5)	14.2 (+ 1.3)	15.0 (+ 0.9)	+ 2.3 % (p<.01)	38	+ 4.3 (19)	+ 40.6 % (8)
	Male	18.3 (n/a)	19.3 (+ 1.1)	20.4 (+ 1.0)	20.9 (+ 0.6)	22.9 (+ 1.9)	23.3 (+ 0.4)	+ 1.7 % (p<.01)			
	Female	3.6 (n/a)	4.2 (+ 0.6)	4.8 (+ 0.6)	5.1 (+ 0.4)	5.8 (+ 0.6)	6.9 (+ 1.2)	+ 4.2 % (p<.01)			
MS	Both	12.9 (n/a)	14.1 (+ 1.2)	14.7 (+ 0.6)	15.5 (+ 0.8)	15.6 (+ 0.1)	15.2 (- 0.3)	+ 1.1 % (p<.05)	36	+ 2.3 (36)	+ 17.8 % (40)
	Male	22.9 (n/a)	24.6 (+ 1.7)	25.1 (+ 0.6)	26.8 (+ 1.7)	25.9 (- 0.9)	25.3 (- 0.6)	+ 0.7 % n/s			
	Female	4.3 (n/a)	5.0 (+ 0.7)	5.5 (+ 0.5)	5.5 (- 0.0)	6.4 (+ 0.9)	6.2 (- 0.2)	+ 2.4 % (p<.01)			
MO	Both	14.7 (n/a)	14.1 (- 0.6)	15.4 (+ 1.3)	16.0 (+ 0.7)	17.8 (+ 1.7)	20.0 (+ 2.3)	+ 2.2 % (p<.01)	16	+ 5.3 (15)	+ 36.4 % (17)
	Male	25.3 (n/a)	23.7 (- 1.6)	25.6 (+ 1.9)	26.6 (+ 1.0)	28.9 (+ 2.3)	32.2 (+ 3.3)	+ 1.8 % (p<.05)			
	Female	5.4 (n/a)	5.4 (+ 0.1)	6.1 (+ 0.7)	6.3 (+ 0.2)	7.4 (+ 1.1)	8.6 (+ 1.2)	+ 3.2 % (p<.01)			
MT	Both	21.1 (n/a)	22.6 (+ 1.4)	23.6 (+ 1.0)	24.7 (+ 1.1)	26.7 (+ 2.0)	29.2 (+ 2.5)	+ 2.1 % (p<.01)	1	+ 8.0 (2)	+ 38.0 % (11)
	Male	36.9 (n/a)	37.3 (+ 0.4)	39.8 (+ 2.5)	39.7 (- 0.1)	41.0 (+ 1.4)	45.5 (+ 4.4)	+ 1.3 % (p<.01)			
	Female	6.7 (n/a)	8.4 (+ 1.8)	8.4 (- 0.1)	10.0 (+ 1.6)	12.6 (+ 2.6)	13.1 (+ 0.5)	+ 4.6 % (p<.01)			
NE	Both	12.7 (n/a)	12.2 (- 0.5)	12.6 (+ 0.4)	11.7 (- 0.8)	13.5 (+ 1.8)	14.8 (+ 1.3)	+ 1.0 % n/s	40	+ 2.1 (42)	+ 16.2 % (43)
	Male	22.2 (n/a)	20.7 (- 1.5)	20.3 (- 0.4)	19.8 (- 0.5)	22.0 (+ 2.2)	23.9 (+ 1.9)	+ 0.6 % n/s			
	Female	3.8 (n/a)	4.2 (+ 0.4)	5.1 (+ 0.9)	4.0 (- 1.1)	5.5 (+ 1.4)	5.8 (+ 0.3)	+ 2.6 % n/s			
NV	Both	23.3 (n/a)	22.6 (- 0.6)	22.1 (- 0.5)	22.6 (+ 0.5)	21.4 (- 1.2)	23.1 (+ 1.6)	- 0.2 % n/s	9	- 0.2 (51)	- 1.0 % (51)
	Male	38.3 (n/a)	36.7 (- 1.7)	35.1 (- 1.6)	35.6 (+ 0.5)	32.5 (- 3.0)	35.4 (+ 2.8)	- 0.7 % n/s			
	Female	8.9 (n/a)	9.5 (+ 0.5)	9.6 (+ 0.1)	10.0 (+ 0.4)	10.6 (+ 0.6)	11.2 (+ 0.6)	+ 1.5 % (p<.01)			
NH	Both	13.5 (n/a)	12.5 (- 1.0)	13.3 (+ 0.8)	15.2 (+ 1.9)	15.8 (+ 0.6)	20.0 (+ 4.2)	+ 2.7 % (p<.05)	17	+ 6.5 (8)	+ 48.3 % (3)
	Male	22.5 (n/a)	21.1 (- 1.4)	21.7 (+ 0.6)	24.8 (+ 3.1)	25.4 (+ 0.6)	30.6 (+ 5.2)	+ 2.2 % (p<.05)			
	Female	5.3 (n/a)	4.8 (- 0.5)	5.9 (+ 1.0)	6.2 (+ 0.4)	6.6 (+ 0.4)	9.8 (+ 3.2)	+ 3.9 % (p<.05)			
NJ	Both	7.8 (n/a)	7.7 (- 0.1)	7.5 (- 0.2)	8.0 (+ 0.5)	8.9 (+ 0.9)	9.2 (+ 0.4)	+ 1.3 % (p<.05)	50	+ 1.5 (47)	+ 19.2 % (35)
	Male	13.0 (n/a)	13.1 (+ 0.0)	12.6 (- 0.5)	13.7 (+ 1.1)	14.5 (+ 0.8)	14.6 (+ 0.1)	+ 0.9 % (p<.05)			
	Female	3.2 (n/a)	2.9 (- 0.3)	3.0 (+ 0.0)	2.9 (- 0.1)	3.8 (+ 0.9)	4.4 (+ 0.6)	+ 2.3 % n/s			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
NM	Both	22.0 (n/a)	22.0 (- 0.1)	21.8 (- 0.2)	23.0 (+ 1.2)	24.1 (+ 1.1)	26.0 (+ 1.9)	+ 1.1 % (p<.05)	4	+ 4.0 (24)	+ 18.3 % (39)
	Male	36.8 (n/a)	37.7 (+ 0.9)	36.4 (- 1.2)	35.8 (- 0.6)	37.1 (+ 1.3)	40.7 (+ 3.6)	+ 0.4 % n/s			
	Female	8.5 (n/a)	7.4 (- 1.1)	8.2 (+ 0.7)	10.7 (+ 2.6)	11.7 (+ 0.9)	12.0 (+ 0.3)	+ 3.3 % (p<.05)			
NY	Both	7.2 (n/a)	7.1 (- 0.1)	7.7 (+ 0.6)	8.4 (+ 0.8)	9.5 (+ 1.1)	9.3 (- 0.1)	+ 2.1 % (p<.01)	49	+ 2.1 (41)	+ 28.8 % (27)
	Male	12.5 (n/a)	12.2 (- 0.3)	12.9 (+ 0.7)	13.9 (+ 1.0)	15.4 (+ 1.4)	14.5 (- 0.9)	+ 1.4 % (p<.05)			
	Female	2.7 (n/a)	2.6 (- 0.1)	3.0 (+ 0.3)	3.5 (+ 0.5)	4.2 (+ 0.7)	4.6 (+ 0.5)	+ 4.2 % (p<.01)			
NC	Both	13.6 (n/a)	13.5 (- 0.1)	13.7 (+ 0.1)	14.2 (+ 0.5)	14.5 (+ 0.4)	15.3 (+ 0.8)	+ 0.8 % (p<.01)	34	+ 1.7 (44)	+ 12.7 % (47)
	Male	22.7 (n/a)	22.7 (+ 0.0)	22.2 (- 0.6)	23.3 (+ 1.1)	23.3 (+ 0.0)	23.9 (+ 0.6)	+ 0.4 % n/s			
	Female	5.6 (n/a)	5.5 (- 0.2)	6.2 (+ 0.8)	6.0 (- 0.2)	6.7 (+ 0.7)	7.6 (+ 0.9)	+ 2.0 % (p<.05)			
ND	Both	13.3 (n/a)	14.6 (+ 1.3)	16.0 (+ 1.4)	16.6 (+ 0.6)	18.4 (+ 1.9)	20.9 (+ 2.5)	+ 2.9 % (p<.01)	14	+ 7.6 (5)	+ 57.6 % (1)
	Male	21.4 (n/a)	24.6 (+ 3.2)	28.0 (+ 3.4)	27.1 (- 0.9)	29.6 (+ 2.5)	32.7 (+ 3.0)	+ 2.5 % (p<.01)			
	Female	5.6 (n/a)	4.5 (- 1.0)	3.7 (- 0.8)	5.7 (+ 2.0)	6.7 (+ 1.0)	8.5 (+ 1.8)	+ 3.9 % n/s			
OH	Both	11.6 (n/a)	12.3 (+ 0.8)	13.1 (+ 0.8)	13.4 (+ 0.2)	14.8 (+ 1.4)	15.8 (+ 1.0)	+ 2.0 % (p<.01)	32	+ 4.2 (21)	+ 36.0 % (19)
	Male	20.4 (n/a)	20.9 (+ 0.5)	22.2 (+ 1.3)	22.1 (- 0.1)	24.2 (+ 2.1)	25.5 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.0 (n/a)	4.7 (+ 0.7)	4.9 (+ 0.1)	5.3 (+ 0.5)	6.2 (+ 0.9)	6.7 (+ 0.6)	+ 3.4 % (p<.01)			
OK	Both	17.0 (n/a)	16.5 (- 0.6)	17.2 (+ 0.8)	18.4 (+ 1.1)	20.7 (+ 2.3)	23.5 (+ 2.8)	+ 2.3 % (p<.05)	7	+ 6.4 (10)	+ 37.6 % (12)
	Male	28.5 (n/a)	27.3 (- 1.2)	27.8 (+ 0.5)	30.3 (+ 2.5)	33.4 (+ 3.1)	37.3 (+ 3.8)	+ 2.0 % (p<.05)			
	Female	6.6 (n/a)	6.4 (- 0.2)	7.5 (+ 1.1)	7.0 (- 0.5)	8.5 (+ 1.6)	10.3 (+ 1.8)	+ 2.9 % (p<.05)			
OR	Both	16.4 (n/a)	17.7 (+ 1.3)	17.7 (- 0.0)	18.6 (+ 0.9)	19.8 (+ 1.2)	21.1 (+ 1.3)	+ 1.6 % (p<.01)	13	+ 4.6 (18)	+ 28.2 % (28)
	Male	27.4 (n/a)	29.5 (+ 2.1)	28.5 (- 0.9)	29.5 (+ 1.0)	31.4 (+ 1.8)	33.0 (+ 1.6)	+ 1.1 % (p<.01)			
	Female	6.5 (n/a)	7.1 (+ 0.6)	7.7 (+ 0.6)	8.4 (+ 0.7)	8.8 (+ 0.4)	9.8 (+ 0.9)	+ 2.7 % (p<.01)			
PA	Both	12.1 (n/a)	12.5 (+ 0.4)	12.8 (+ 0.3)	13.9 (+ 1.1)	15.0 (+ 1.1)	16.3 (+ 1.2)	+ 2.0 % (p<.01)	30	+ 4.1 (22)	+ 34.3 % (21)
	Male	21.0 (n/a)	21.3 (+ 0.3)	21.9 (+ 0.6)	23.1 (+ 1.2)	24.7 (+ 1.7)	26.1 (+ 1.3)	+ 1.5 % (p<.01)			
	Female	4.2 (n/a)	4.6 (+ 0.3)	4.6 (+ 0.0)	5.4 (+ 0.9)	6.0 (+ 0.6)	7.1 (+ 1.1)	+ 3.5 % (p<.01)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016											
State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
RI	Both	9.4 (n/a)	9.0 (- 0.3)	9.0 (- 0.0)	12.8 (+ 3.8)	11.9 (- 0.9)	12.6 (+ 0.7)	+ 2.6 % (p<.05)	43	+ 3.2 (30 ¶¶)	+ 34.1 % (23 ¶¶)
	Male	15.4 (n/a)	15.2 (- 0.2)	14.8 (- 0.3)	21.2 (+ 6.4)	19.2 (- 2.0)	19.6 (+ 0.4)	+ 2.2 % n/s			
	Female	4.0 (n/a)	3.3 (- 0.7)	3.8 (+ 0.4)	5.1 (+ 1.3)	5.1 (+ 0.0)	6.1 (+ 1.0)	+ 3.7 % (p<.05)			
SC	Both	12.8 (n/a)	13.0 (+ 0.2)	13.7 (+ 0.7)	14.9 (+ 1.2)	16.0 (+ 1.1)	17.7 (+ 1.7)	+ 2.3 % (p<.01)	23	+ 4.9 (17)	+ 38.3 % (10)
	Male	21.3 (n/a)	22.5 (+ 1.2)	22.3 (- 0.1)	24.6 (+ 2.2)	26.1 (+ 1.5)	28.0 (+ 1.9)	+ 1.8 % (p<.01)			
	Female	5.4 (n/a)	4.7 (- 0.7)	6.0 (+ 1.3)	6.2 (+ 0.2)	7.0 (+ 0.8)	8.4 (+ 1.4)	+ 3.4 % (p<.05)			
SD	Both	15.7 (n/a)	15.8 (+ 0.1)	17.1 (+ 1.3)	19.3 (+ 2.2)	19.7 (+ 0.4)	22.6 (+ 2.9)	+ 2.5 % (p<.01)	10	+ 7.0 (7)	+ 44.5 % (6)
	Male	27.6 (n/a)	26.3 (- 1.3)	27.9 (+ 1.6)	30.1 (+ 2.2)	32.0 (+ 1.9)	33.6 (+ 1.6)	+ 1.6 % (p<.01)			
	Female	4.2 (n/a)	5.8 (+ 1.6)	6.4 (+ 0.6)	8.3 (+ 2.0)	7.3 (- 1.0)	11.3 (+ 4.0)	+ 5.8 % (p<.01)			
TN	Both	14.6 (n/a)	15.2 (+ 0.6)	16.1 (+ 0.8)	17.2 (+ 1.1)	17.2 (+ 0.0)	18.2 (+ 1.0)	+ 1.4 % (p<.01)	22	+ 3.5 (28)	+ 24.2 % (31)
	Male	25.1 (n/a)	25.4 (+ 0.3)	26.8 (+ 1.3)	28.0 (+ 1.2)	28.6 (+ 0.6)	29.8 (+ 1.2)	+ 1.2 % (p<.01)			
	Female	5.4 (n/a)	6.3 (+ 0.9)	6.7 (+ 0.4)	7.5 (+ 0.8)	6.9 (- 0.6)	7.6 (+ 0.7)	+ 1.9 % (p<.05)			
TX	Both	12.2 (n/a)	12.7 (+ 0.6)	12.3 (- 0.4)	13.2 (+ 0.9)	13.6 (+ 0.3)	14.5 (+ 0.9)	+ 1.1 % (p<.01)	41	+ 2.3 (37)	+ 18.9 % (36)
	Male	20.4 (n/a)	20.9 (+ 0.5)	20.4 (- 0.6)	22.0 (+ 1.6)	22.2 (+ 0.3)	23.1 (+ 0.9)	+ 0.9 % (p<.05)			
	Female	4.8 (n/a)	5.4 (+ 0.6)	5.0 (- 0.4)	5.2 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.8)	+ 1.6 % (p<.05)			
UT	Both	17.2 (n/a)	19.0 (+ 1.8)	18.2 (- 0.7)	20.2 (+ 2.0)	24.0 (+ 3.8)	25.2 (+ 1.2)	+ 2.7 % (p<.01)	5	+ 8.0 (3 ¶¶)	+ 46.5 % (4 ¶¶)
	Male	28.2 (n/a)	31.1 (+ 2.9)	29.4 (- 1.7)	32.1 (+ 2.7)	37.8 (+ 5.7)	38.0 (+ 0.2)	+ 2.1 % (p<.05)			
	Female	6.8 (n/a)	7.4 (+ 0.6)	7.5 (+ 0.1)	8.5 (+ 1.0)	10.6 (+ 2.1)	12.6 (+ 2.0)	+ 4.4 % (p<.01)			
VT	Both	13.2 (n/a)	16.2 (+ 3.0)	14.9 (- 1.3)	16.6 (+ 1.7)	18.7 (+ 2.1)	19.7 (+ 1.0)	+ 2.4 % (p<.01)	18	+ 6.4 (9)	+ 48.6 % (2)
	Male	23.6 (n/a)	28.3 (+ 4.6)	24.3 (- 4.0)	27.3 (+ 3.0)	31.0 (+ 3.7)	32.5 (+ 1.5)	+ 1.9 % (p<.05)			
	Female	4.3 (n/a)	5.2 (+ 0.9)	6.4 (+ 1.3)	6.6 (+ 0.2)	7.3 (+ 0.7)	7.6 (+ 0.3)	+ 3.8 % (p<.01)			
VA	Both	12.8 (n/a)	12.7 (- 0.1)	12.9 (+ 0.3)	13.6 (+ 0.7)	14.6 (+ 0.9)	15.0 (+ 0.5)	+ 1.2 % (p<.01)	37	+ 2.2 (39)	+ 17.4 % (41)
	Male	21.6 (n/a)	21.3 (- 0.2)	21.0 (- 0.4)	22.5 (+ 1.5)	23.6 (+ 1.2)	23.9 (+ 0.2)	+ 0.9 % (p<.05)			
	Female	5.3 (n/a)	5.2 (- 0.1)	5.9 (+ 0.7)	5.6 (- 0.3)	6.4 (+ 0.8)	6.9 (+ 0.5)	+ 1.8 % (p<.05)			

Supplementary Table. Trends in Suicide Rates among Persons ≥ 10 Years of Age, by State and Sex, National Vital Statistics System, 1999 – 2016

State	Sex	Age-Adjusted Annual Rate per 100,000 Persons (Change from Prior Period) *						Modeled AAPC †	Current State Rank §	Overall Rate Change (State Rank) ¶	Overall Percent Change (State Rank) **
		1999 – 2001	2002 – 2004	2005 – 2007	2008 – 2010	2011 – 2013	2014 – 2016				
WA	Both	14.8 (n/a)	15.4 (+ 0.5)	14.8 (- 0.6)	15.7 (+ 0.9)	16.6 (+ 0.9)	17.6 (+ 1.0)	+ 1.1 % (p<.05)	24	+ 2.8 (33)	+ 18.8 % (37)
	Male	24.7 (n/a)	25.2 (+ 0.5)	24.1 (- 1.1)	25.1 (+ 1.0)	26.0 (+ 0.9)	27.1 (+ 1.1)	+ 0.6 % n/s			
	Female	5.9 (n/a)	6.4 (+ 0.6)	6.2 (- 0.2)	6.9 (+ 0.7)	7.7 (+ 0.8)	8.5 (+ 0.8)	+ 2.5 % (p<.01)			
WV	Both	15.6 (n/a)	17.2 (+ 1.6)	16.7 (- 0.5)	16.0 (- 0.7)	19.2 (+ 3.2)	21.4 (+ 2.2)	+ 1.8 % n/s	11	+ 5.8 (13)	+ 37.1 % (14)
	Male	27.2 (n/a)	30.1 (+ 2.9)	28.6 (- 1.5)	27.6 (- 1.0)	31.5 (+ 3.9)	33.5 (+ 2.0)	+ 1.1 % n/s			
	Female	5.3 (n/a)	5.5 (+ 0.1)	5.8 (+ 0.3)	5.3 (- 0.5)	7.6 (+ 2.3)	9.8 (+ 2.2)	+ 3.7 % n/s			
WI	Both	13.1 (n/a)	13.5 (+ 0.4)	14.0 (+ 0.5)	15.0 (+ 1.0)	15.3 (+ 0.3)	16.5 (+ 1.2)	+ 1.5 % (p<.01)	28	+ 3.4 (29)	+ 25.8 % (30)
	Male	21.7 (n/a)	22.2 (+ 0.5)	22.7 (+ 0.5)	24.0 (+ 1.2)	24.4 (+ 0.4)	25.7 (+ 1.3)	+ 1.1 % (p<.01)			
	Female	5.1 (n/a)	5.3 (+ 0.2)	5.6 (+ 0.4)	6.4 (+ 0.7)	6.5 (+ 0.1)	7.5 (+ 1.0)	+ 2.5 % (p<.01)			
WY	Both	20.7 (n/a)	23.4 (+ 2.7)	22.5 (- 0.9)	25.4 (+ 2.8)	28.9 (+ 3.5)	28.8 (- 0.1)	+ 2.3 % (p<.01)	3	+ 8.1 (1)	+ 39.0 % (9)
	Male	34.8 (n/a)	39.3 (+ 4.5)	36.3 (- 3.0)	41.5 (+ 5.2)	47.1 (+ 5.6)	44.6 (- 2.4)	+ 1.8 % (p<.05)			
	Female	7.7 (n/a)	8.2 (+ 0.6)	9.2 (+ 0.9)	9.4 (+ 0.2)	10.7 (+ 1.4)	12.6 (+ 1.9)	+ 3.2 % (p<.01)			

* Rates are age-adjusted to the U.S. year 2000 standard.

† Model-estimated average annual percentage change (AAPC) based on all reporting periods; p-value indicates statistical significance of trend; n/s indicates trend not significant.

§ Current state rank (50 states and the District of Columbia) is for the reporting period 2014 – 2016. Ranks are from highest rate (1) to lowest rate (51). Different ranks do not necessarily imply a statistically significant difference.

¶ Overall rate change is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest increase (1) to largest decrease (51). Different ranks do not necessarily imply a statistically significant difference.

** Overall percent change in rates is between the first (1999 – 2001) and last (2014 – 2016) reporting periods. Ranks are from largest percentage increase (1) to largest percentage decrease (51). Different ranks do not necessarily imply a statistically significant difference.

†† Rate based on < 20 suicides.

§§ Percentage of injury deaths for which intent was not determined exceeded 20% for both the first and last periods and might have contributed to lower reported rates.

¶¶ Percentage of injury deaths for which intent was not determined declined notably between the first and last periods and might have contributed to the reported rate increase.

State Abbreviations: AL Alabama; AK Alaska; AZ Arizona; AR Arkansas; CA California; CO Colorado; CT Connecticut; DE Delaware; DC District of Columbia; FL Florida; GA Georgia; HI Hawaii; ID Idaho; IL Illinois; IN Indiana; IA Iowa; KS Kansas; KY Kentucky; LA Louisiana; ME Maine; MD Maryland; MA Massachusetts; MI Michigan; MN Minnesota; MS Mississippi; MO Missouri; MT Montana; NE Nebraska; NV Nevada; NH New Hampshire; NJ New Jersey; NM New Mexico; NY New York; NC North Carolina; ND North Dakota; OH Ohio; OK Oklahoma; OR Oregon; PA Pennsylvania; RI Rhode Island; SC South Carolina; SD South Dakota; TN Tennessee; TX Texas; UT Utah; VT Vermont; VA Virginia; WA Washington; WV West Virginia; WI Wisconsin; WY Wyoming.

From: Sokler, Lynn (CDC/OD/OADC)
Sent: 6 Jun 2018 16:43:21 -0400
To: Houry, Debra E. (CDC/ONDIEH/NCIPC);Lenard, Courtney (CDC/ONDIEH/NCIPC);Dorigo, Leslie (CDC/ONDIEH/NCIPC);Stone, Deborah (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Simon, Thomas (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Gaines-McCollom, Molly (CDC/OPHPR/DEO);DeNoon, Daniel (CDC/OD/OADC) (CTR);Grusich, Katherina (Kate) (CDC/OD/OADC);Hoskins, Sharon (K.D.) (CDC/OD/OADC);Iverson, Dontae (CDC/OD/OADC);Balluz, Lina (ATSDR/DTHHS/OD);Bonds, Michelle E. (CDC/OD/OADC);Brand, Anstice M. (CDC/OD/CDCWO);Brown, Renee (CDC/ONDIEH/NCCDPHP);Bumpus, Stefanie (CDC/OID/NCEZID);Burden, Bernadette (CDC/OD/OADC);Burns, Annina (CDC/OD/CDCWO);Charles, Julia (CDC/OD/OCS);Clark, Cynthia K. (CDC/OD/OCS);Crawford, Carol Y. (CDC/OD/OADC);Daniel, Katherine Lyon (CDC/OD/OADC);Das, Mansi S. (CDC/OD/OADC);Dempsey, Jay H. (CDC/OD/OADC);Diaz, Shelly S. (CDC/OID/NCHHSTP);Dills, Kimberly C. (ATSDR/OPPE);DPAID (CDC);Dunn, Evelyn (CDC/OCOO/OFR/OA);Galatas, Kate (CDC/OD/OADC);Gonzalez, Belsie (CDC/OD/OADC);Grant, Llelwyn (CDC/OD/OADC);Green, Hugh (CDC/OD/OCS);Guest, Megan (CDC/OD/OADC);Heldman, Amy B. (CDC/OD/OADC);Hogg, Jarrad (CDC/OD/OADC);Hoo, Elizabeth (CDC/OD/PPEO);Iademarco, Michael (CDC/OPHSS/CSELS/OD);Joyner, Tonya (CDC/OSTLTS/OD) (CTR);Kelly, Alison (CDC/OCOO/OFR/OA);Kent, Charlotte (CDC/OPHSS/CSELS/DPHID);Knight, Dianna (CDC/OD/OADC);Knotts, Ashley (CDC/OD/OCS);Kroop, Seth (CDC/OD/OCS);Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD);Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD);McGowan, Robert (Kyle) (CDC/OD/OCS);Olivares, Dagny (CDC/OSTLTS/OD);Parikh, Sapana (CDC/OCOO/OFR/OA);Parker, Stacey M. (CDC/OSTLTS/OD) (CTR);Payne, Chelsea C. (CDC/OSTLTS/OD);Putman, Ami D. (CDC/OPHSS/CSELS/DLS);Rasmussen, Sonja (CDC/OID/OD);Redd, Stephen (CDC/OPHPR/OD);Redfield, Robert R. (CDC/OD);Schattner, Aimee (CDC/OD/CDCWO);Schindelar, Jessica (CDC/OD/OADC);Schuchat, Anne MD (CDC/OD);Simon, Gia M. (CDC/OSTLTS/OD);Smith, Patti (CDC/OD/OADC);Sorrells, Marjorie J. (CDC/OD/OCS);Stanojevich, Joel G. (CDC/CGH/OD);Ware, Nina (CDC/OD/OADS);Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID);Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR);Wilson, Michelle (CDC/OCOO/OFR/OA)
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID);Peaker, Brandy (CDC/OPHSS/CSELS/DPHID);Omisore, Shannon L. (CDC/OD/OADC);Turner, Cheryl L. (CDC/OD/OADC) (CTR);Guest, Megan (CDC/OD/OADC);McGuire, Delaney (CDC/OD/OADC);Roberts, Ursula (CDC/OD/OCS) (CTR);Sokler, Lynn (CDC/OD/OADC)
Subject: Updated Dear Colleague Letter - FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention
Attachments: DEAR COLLEAGUE_V3_6.6.2018 440pm_rev_Final.docx

Hi,
For those of you distributing to partners and stakeholders tomorrow (STLTS, Program, NCIPC, etc.), please use this updated Dear Colleague Letter.
Thanks, Lynn

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Wednesday, June 6, 2018 4:20 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) ; Lenard, Courtney (CDC/ONDIEH/NCIPC) ; Dorigo, Leslie (CDC/ONDIEH/NCIPC) ; Stone, Deborah (CDC/ONDIEH/NCIPC) ; Mercy, James (CDC/ONDIEH/NCIPC) ; Crosby, Alexander (CDC/ONDIEH/NCIPC) ; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) ; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) ; Bruce, Crystal (CDC/OPHPR/OD) ; Simon, Thomas

(CDC/ONDIEH/NCIPC) ; Black, Erin (CDC/ONDIEH/NCIPC) ; Gaines-McCollom, Molly (CDC/OPHPR/DEO) ; DeNoon, Daniel (CDC/OD/OADC) (CTR) ; Grusich, Katherina (Kate) (CDC/OD/OADC) ; Hoskins, Sharon (K.D.) (CDC/OD/OADC) ; Iverson, Dontae (CDC/OD/OADC) ; Balluz, Lina (ATSDR/DTHHS/OD) ; Bonds, Michelle E. (CDC/OD/OADC) ; Brand, Anstice M. (CDC/OD/CDCWO) ; Brown, Renee (CDC/ONDIEH/NCCDPHP) ; Bumpus, Stefanie (CDC/OID/NCEZID) ; Burden, Bernadette (CDC/OD/OADC) ; Burns, Annina (CDC/OD/CDCWO) ; Charles, Julia (CDC/OD/OCS) ; Clark, Cynthia K. (CDC/OD/OCS) ; Crawford, Carol Y. (CDC/OD/OADC) ; Daniel, Katherine Lyon (CDC/OD/OADC) ; Das, Mansi S. (CDC/OD/OADC) ; Dempsey, Jay H. (CDC/OD/OADC) ; Diaz, Shelly S. (CDC/OID/NCHHSTP) ; Dills, Kimberly C. (ATSDR/OPPE) ; DPAID (CDC) ; Dunn, Evelyn (CDC/OCOO/OFR/OA) ; Galatas, Kate (CDC/OD/OADC) ; Gonzalez, Belsie (CDC/OD/OADC) ; Grant, Llelwyn (CDC/OD/OADC) ; Green, Hugh (CDC/OD/OCS) ; Guest, Megan (CDC/OD/OADC) ; Heldman, Amy B. (CDC/OD/OADC) ; Hogg, Jarrad (CDC/OD/OADC) ; Hoo, Elizabeth (CDC/OD/PPEO) ; Iademarco, Michael (CDC/OPHSS/CSELS/OD) ; Joyner, Tonya (CDC/OSTLTS/OD) (CTR) ; Kelly, Alison (CDC/OCOO/OFR/OA) ; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) ; Knight, Dianna (CDC/OD/OADC) ; Knotts, Ashley (CDC/OD/OCS) ; Kroop, Seth (CDC/OD/OCS) ; Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD) ; Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD) ; McGowan, Robert (Kyle) (CDC/OD/OCS) ; Olivares, Dagny (CDC/OSTLTS/OD) ; Parikh, Sapana (CDC/OCOO/OFR/OA) ; Parker, Stacey M. (CDC/OSTLTS/OD) (CTR) ; Payne, Chelsea C. (CDC/OSTLTS/OD) ; Putman, Ami D. (CDC/OPHSS/CSELS/DLS) ; Rasmussen, Sonja (CDC/OID/OD) ; Redd, Stephen (CDC/OPHPR/OD) ; Redfield, Robert R. (CDC/OD) ; Schattner, Aimee (CDC/OD/CDCWO) ; Schindelar, Jessica (CDC/OD/OADC) ; Schuchat, Anne MD (CDC/OD) ; Simon, Gia M. (CDC/OSTLTS/OD) ; Smith, Patti (CDC/OD/OADC) ; Sorrells, Marjorie J. (CDC/OD/OCS) ; Stanojevich, Joel G. (CDC/CGH/OD) ; Ware, Nina (CDC/OD/OADS) ; Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID) ; Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR) ; Wilson, Michelle (CDC/OCOO/OFR/OA)
Cc: Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) ; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) ; Omisore, Shannon L. (CDC/OD/OADC) ; Turner, Cheryl L. (CDC/OD/OADC) (CTR) ; Guest, Megan (CDC/OD/OADC) ; McGuire, Delaney (CDC/OD/OADC) ; Roberts, Ursula (CDC/OD/OCS) (CTR)
Subject: Supplemental Table- FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention

Hi Folks,

Sending a table that will appear in the MMWR. For those of you distributing to others tomorrow morning, please include the table with the other materials.

Thanks, Lynn

From: Sokler, Lynn (CDC/OD/OADC)
Sent: Wednesday, June 6, 2018 2:33 PM
To: Houry, Debra E. (CDC/ONDIEH/NCIPC) <vjz7@cdc.gov>; Lenard, Courtney (CDC/ONDIEH/NCIPC) <zvq5@cdc.gov>; Dorigo, Leslie (CDC/ONDIEH/NCIPC) <fus3@cdc.gov>; Stone, Deborah (CDC/ONDIEH/NCIPC) <zaf9@cdc.gov>; Mercy, James (CDC/ONDIEH/NCIPC) <jam2@cdc.gov>; Crosby, Alexander (CDC/ONDIEH/NCIPC) <aec1@cdc.gov>; Richmond-Crum, Malia (CDC/ONDIEH/NCIPC) <jrv8@cdc.gov>; Fowler, Katherine A. (CDC/ONDIEH/NCIPC) <vid5@cdc.gov>; Bruce, Crystal (CDC/OPHPR/OD) <jgx6@cdc.gov>; Simon, Thomas (CDC/ONDIEH/NCIPC) <tgs9@cdc.gov>; Black, Erin (CDC/ONDIEH/NCIPC) <epm7@cdc.gov>; Gaines-McCollom, Molly (CDC/OPHPR/DEO) <iwg9@cdc.gov>; DeNoon, Daniel (CDC/OD/OADC) (CTR) <xlz4@cdc.gov>; Grusich, Katherina (Kate) (CDC/OD/OADC) <yhb3@cdc.gov>; Hoskins, Sharon (K.D.) (CDC/OD/OADC) <sdh4@cdc.gov>; Iverson, Dontae (CDC/OD/OADC) <liz8@cdc.gov>; Balluz, Lina (ATSDR/DTHHS/OD) <lib7@cdc.gov>; Bonds, Michelle E. (CDC/OD/OADC) <meb0@cdc.gov>; Brand, Anstice M. (CDC/OD/CDCWO) <atb6@cdc.gov>; Brown, Renee (CDC/ONDIEH/NCCDPHP) <ryb8@cdc.gov>; Bumpus, Stefanie (CDC/OID/NCEZID) <wve1@cdc.gov>; Burden, Bernadette (CDC/OD/OADC) <btb8@cdc.gov>; Burns, Annina (CDC/OD/CDCWO) <vjg7@cdc.gov>; Charles, Julia (CDC/OD/OCS) <yyb1@cdc.gov>; Clark, Cynthia K.

(CDC/OD/OCS) <cfc8@cdc.gov>; Crawford, Carol Y. (CDC/OD/OADC) <cjy1@cdc.gov>; Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>; Das, Mansi S. (CDC/OD/OADC) <hrg7@cdc.gov>; Dempsey, Jay H. (CDC/OD/OADC) <ifb5@cdc.gov>; Diaz, Shelly S. (CDC/OID/NCHHSTP) <erh8@cdc.gov>; Dills, Kimberly C. (ATSDR/OPPE) <kid4@cdc.gov>; DPAID (CDC) <dpaid@cdc.gov>; Dunn, Evelyn (CDC/OCOO/OFR/OA) <edm2@cdc.gov>; Galatas, Kate (CDC/OD/OADC) <kkg2@cdc.gov>; Gonzalez, Belsie (CDC/OD/OADC) <fqi1@cdc.gov>; Grant, Llelwyn (CDC/OD/OADC) <lcg7@cdc.gov>; Green, Hugh (CDC/OD/OCS) <yke8@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>; Heldman, Amy B. (CDC/OD/OADC) <evd4@cdc.gov>; Hogg, Jarrad (CDC/OD/OADC) <isr5@cdc.gov>; Hoo, Elizabeth (CDC/OD/PPEO) <irp5@cdc.gov>; Iademarco, Michael (CDC/OPHSS/CSELS/OD) <mai9@cdc.gov>; Joyner, Tonya (CDC/OSTLTS/OD) (CTR) <wyl6@cdc.gov>; Kelly, Alison (CDC/OCOO/OFR/OA) <ayk7@cdc.gov>; Kent, Charlotte (CDC/OPHSS/CSELS/DPHID) <cgk3@cdc.gov>; Knight, Dianna (CDC/OD/OADC) <fpz0@cdc.gov>; Knotts, Ashley (CDC/OD/OCS) <vqf0@cdc.gov>; Kroop, Seth (CDC/OD/OCS) <wpw7@cdc.gov>; Mac Kenzie, William R. (CDC/OPHSS/CSELS/OD) <wrm0@cdc.gov>; Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD) <lym1@cdc.gov>; McGowan, Robert (Kyle) (CDC/OD/OCS) <omc2@cdc.gov>; Olivares, Dagny (CDC/OSTLTS/OD) <dvp2@cdc.gov>; Parikh, Sapana (CDC/OCOO/OFR/OA) <euh8@cdc.gov>; Parker, Stacey M. (CDC/OSTLTS/OD) (CTR) <vgw3@cdc.gov>; Payne, Chelsea C. (CDC/OSTLTS/OD) <cec4@cdc.gov>; Putman, Ami D. (CDC/OPHSS/CSELS/DLS) <ibv5@cdc.gov>; Rasmussen, Sonja (CDC/OID/OD) <skr9@cdc.gov>; Redd, Stephen (CDC/OPHPR/OD) <scr1@cdc.gov>; Redfield, Robert R. (CDC/OD) <olx1@cdc.gov>; Schattner, Aimee (CDC/OD/CDCWO) <xjj4@cdc.gov>; Schindelar, Jessica (CDC/OD/OADC) <ghq1@cdc.gov>; Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; Simon, Gia M. (CDC/OSTLTS/OD) <wpc8@cdc.gov>; Smith, Patti (CDC/OD/OADC) <pab0@cdc.gov>; Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Sorrells, Marjorie J. (CDC/OD/OCS) <isg8@cdc.gov>; Stanojevich, Joel G. (CDC/CGH/OD) <vhi9@cdc.gov>; Ware, Nina (CDC/OD/OADS) <evy5@cdc.gov>; Weatherwax, Douglas (CDC/OPHSS/CSELS/DPHID) <aoe8@cdc.gov>; Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR) <kcv7@cdc.gov>; Wilson, Michelle (CDC/OCOO/OFR/OA) <zwv2@cdc.gov>
Cc: Sokler, Lynn (CDC/OD/OADC) <zsz0@cdc.gov>; Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID) <rbs4@cdc.gov>; Peaker, Brandy (CDC/OPHSS/CSELS/DPHID) <vha6@cdc.gov>; Omisore, Shannon L. (CDC/OD/OADC) <hyl5@cdc.gov>; Turner, Cheryl L. (CDC/OD/OADC) (CTR) <ffd0@cdc.gov>; Guest, Megan (CDC/OD/OADC) <weo6@cdc.gov>; McGuire, Delaney (CDC/OD/OADC) <mze7@cdc.gov>; Roberts, Ursula (CDC/OD/OCS) (CTR) <nka7@cdc.gov>
Subject: FINAL MATERIALS FOR DISTRIBUTION: June 7 - Vital Signs Suicide Prevention

Hi Folks,

This month's issue of Vital Signs is on **Suicide Rates Rising across the U.S.** and releases **Thursday, June 7** with a Media Telebriefing at noon. **All materials go live on the CDC website at 1 pm**. Here are the key materials to use to distribute to stakeholders and partners: The Dear Colleague letter, MMWR, Fact Sheet, Press Release and Graphic.

For those distributing to media, please send the MMWR, Fact Sheet, Press Release and Graphic. Dr. Schuchat will be the primary spokesperson for this Vital Signs.

For those of you distributing out to partners and other constituents Thursday morning at 9 am, please make sure they know these are advance copies only. These materials are **embargoed until Thursday June 7 at 1 pm**. Please adjust the Dear Colleague letter for those people to which you send. Also please send Rich and me a copy when you email this out to your groups.

We will also have the press release on CDC en Espanol and available through the Vital Signs website.

For those attending the media telebriefing, I have also attached the Telebriefing Script and the Q&A document. **These do not get distributed externally.**

For each Vital Signs issue, we track and report on results **two times** – after 24 hours and after 30 days. We track the number of audiences reached (from all media and web sources), # of stories and type of media, the dollar value of the media coverage if CDC had to purchase it as advertising, social media use and reuse, and # of people looking at Vital Signs on our web pages.

Vital Signs reaches out to a lot of different people with our topics and, from our evaluation surveys, the uptake out in the field is impressive. In a survey, an astounding **95%** of state health officers and state epidemiologists were aware of and used VS issues, with about 3 in 4 using VS in the past year. All shared the material with their constituents via conference call, e-mail, newsletter, or mailing for topics appropriate to their members. A stratified random sample survey, used with NACCHO member organizations, reported that **74%** of all county or local health departments had heard of or used VS in the past year to educate staff, improve programs, and guide policy formation. As well, a 2017 internal evaluation showed that most program staff involved believe the value derived from it is worth the work, although producing Vital Signs takes a lot of effort.

I want to thank everyone who has worked on this issue for all their extra efforts. It's a very important topic and will be valuable information for many people. We hope that program continues to use this Vital Signs to promote its messages and the recommended actions in it to achieve new results.

Cheers,

Lynn

Lynn A. Sokler|Senior Communication Advisor|Office of the Director|Office of the Associate Director for Communication| Centers for Disease Control and Prevention|Mailing: 1600 Clifton Road MS-E-69| Atlanta, GA 30329| zsz0@cdc.gov| office 404-498-6617 |bus. cell 404-409-5556|fx 404-498-0945



Dear Colleague:

The CDC *Vital Signs* series, launched in 2010, addresses a single, important public health topic each month. This month's edition presents trends in suicide rates across all states and D.C., examines contributing factors to suicide in 27 states, and highlights strategies for comprehensive suicide prevention. We also highlight strategies for state public health departments and others working to help reduce suicides.

This e-mail contains advance copies of several *Vital Signs* materials, including the *Morbidity and Mortality Weekly Report (MMWR)* article, "Vital Signs: Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates," and a four-page consumer fact sheet. **This latest edition of *CDC Vital Signs* will be released today, Thursday, June 7, 2018, at 1:00 pm (EST) following a media telebriefing at noon; all attached materials are EMBARGOED until 1pm EST.**

Key points in the *Vital Signs* report include:

- In 2016, nearly 45,000 suicides occurred in the US among people 10 years and older
- From 1999-2016, suicide rates increased in nearly every state, with 25 states experiencing increases of more than 30% each
- Data from 27 states participating in the National Violent Death Reporting System in 2015 indicate that more than half of people who died by suicide did not have a known mental health condition
- A range of factors contributes to suicide beyond mental health conditions alone, including relationship, substance use, physical health, job, financial, and legal problems.

After the embargo is lifted today at 1 pm (EDT), please share the *CDC Vital Signs* information broadly with your colleagues and partners. Visit the *Vital Signs* Web page to find the *MMWR* article, fact sheet, and other materials. Take advantage of CDC's social media tools, such as the *Vital Signs* buttons and email updates. Visit CDC's Public Health Media Library at www.cdc.gov/syndication and search on the term Vital Signs. We also invite you to join us for the *Vital Signs* Town Hall Teleconference on June 12 at 2:00 pm (EST).

Vital Signs is about more than data, it is about action. We look forward to continuing our work together to prevent suicides and promoting healthier communities.

Thank you for your support.

Debra Houry, MD, MPH
Director
National Center for Injury Prevention and Control

James A. Mercy, PhD
Director
Division of Violence Prevention
National Center for Injury Prevention and Control

From: Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Sent: 17 Jan 2018 17:25:45 -0500
To: Stone, Deborah (CDC/ONDIEH/NCIPC);Simon, Thomas (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC)
Cc: Black, Erin (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC)
Subject: Vital Signs Suicide mini-partnership engagement plan
Attachments: Partnership Outreach Plan - Vital Signs June 2018_v2.docx, Copy of June 2018 Deliverables calendar_21Nov2017.xlsx

Hi everyone,
Wanted to share the latest version of the draft partnership engagement plan for the Vital Signs release. I wanted to share this before Friday's Suicide Center briefing for your awareness.
Have discussed with Erin and Jim and the plan is to not share this document on Friday however I can provide highlights and let everyone know that we've begun to engage select partners on potential joint activities . We will share a draft plan, in writing, at the next briefing in March to gather Center, DARPI and DUIP leadership feedback.
I would appreciate any feedback you have the plan – feel free to email or we can discuss as a group at next week's Vital Signs prep meeting.
A few things to keep in mind when you look at it:

- This plan includes activities in addition to those normally planned by CDC e.g., town hall, dear colleague letter, press release etc. so those are not included here.
- Activities that rely on partner resources (e.g. webinars) are not confirmed, just ideas at this point and may change as we reach out to this partners to explore ideas for dissemination together.
- I've included ideas that will require support from you all as the authors– such as conference presentations. These are only ideas as this point and can be changed, I realize this requires effort from you so we should definitely come to agreement on these activities before sharing a draft with Center leadership in March.
- The list at the bottom of the document is still a brainstorm/running list for reference (please add anything we've missed!). I think it probably makes sense to create a tiered partner list for engagement but haven't done that yet. It may look something like:
    1. High engagement - Select partners that work on suicide prevention or directly with state suicide professionals that will receive the most engagement such as a personalized letter from Jim or will work with DVP to plan a webinar or conference call for their members e.g., Action Alliance
    2. Medium engagement – Organizations that may use resources such as infographics in communications materials, website etc. e.g., NCSL
    3. Basic engagement -- Orgs/people receiving widely disseminated partner announcements e.g., Entire DVP partners list, (~ 770 people), NCIPC distro list.

Thanks to Crystal, Molly and Erin for doing the first round of reviews/feedback!
Please let me know if you have any questions.
Malia

Vital Signs DVP Partnership Outreach Plan - Draft (01/16/2018)
Launch date – June 5, 2018

Goals:

- Promote Vital Signs findings broadly to all DVP partners
- Engage select partners through enhanced promotion activities to advance uptake of VS findings and DVP suicide prevention strategies and work

Activities	Date	Partners	Staff
Outreach to select partners to identify engagement opportunities for VS dissemination after June 5 release • Action Alliance – Feb 1	Jan-May	Action Alliance AFSP APHA ASTHO NIH – NIMH NIH -- NIDA Safe States SAMHSA SPRC VA [others?]	Erin Malia Heather Val Molly Crystal
Action Alliance ExCom Meeting – brief ExCom members about Vital Signs release	March	Action Alliance members	Jim Mercy (Anne Schuchat/Deb Houry)
Email to prime DVP Policy Network partners for release and ask them to disseminate	May 5	DVP Policy Network	Erin
Conference call with DVP Policy Network to brainstorm opportunities for dissemination after VS release	May 8	DVP Policy Network	Erin
Share embargoed findings with State Health Departments for awareness of state data	TBD (June 3?)	State health officers Injury directors Suicide prevention directors NVDRS coordinators State public health communications officers	TBD (Coordinate with VS team and OSTLTS)
Email VS Announcement to ~700 DVP partners	June 5	DVP partner list	TBD
Tailored email from Jim and Deb H. to select partner	June 5	ACPM	TBD

organizations		ACEP Action Alliance AFSP APHA ASTHO NGA suicide meeting participants NIH - NIMH NIH - NIDA Saddleback Church Safe States SAMHSA SPRC DOD VA (others)	Jim Deb
Emails to key Congressional offices	June 5	TBD	Malia Heather Melissa Cyril CDCW
Medscape Commentary	June?	Physicians	Crystal
Safe States Alliance Webinar • Audience: State injury and suicide prevention directors and staff; researchers	Mid-June	Safe States Alliance	Malia VS authors
Nat'l Action Alliance for Suicide Prevention Webinar • Audience: Suicide prevention practitioners, faith-based orgs, businesses, XXXX	Mid to late June	National Action Alliance for Suicide Prevention	Erin VS authors
NIH-NIMH webinar • Audience: Researchers, MH practitioners	Mid to late June	NIH	TBD
ASTHO's Substance Abuse and Addiction Workgroup conference call presentation • Audience: State health offices, deputies, ASTHO staff	TBD	ASTHO	Malia VS authors
National Conference of State Legislators blog post or newsletter article	July	NCSL	Malia Elizabeth Z
National Governor's Association webinar or newsletter	TBD	NGA	Erin

article			
DVP Digest highlight	June/July	DVP partner list	Maddy
DVP Policy Network quarterly call presentation	August 14	DVP Policy Network	TBD
Safe States Alliance Annual Conference presentation on VS data and DVP suicide technical package prevention strategies	Sept 5-7	Safe States Alliance State injury and violence prevention directors	VS authors
ASTHO 2018 Policy Summit & Annual Meeting presentation VS data and DVP suicide technical package prevention strategies	Sept 25-27	State public health leaders State leg liaisons	VS authors
APHA Annual Conference presentation VS data and DVP suicide technical package prevention strategies	Nov 10-14	Public health practitioners and leaders	VS authors

Potential Partner List For VS release (Draft)
Professional/Trade Org
American Academy of Emergency Medicine
American Academy of Family Physicians
American Academy of Emergency Physicians
American Assn of Suicidology
American College of Emergency Physicians
American College of Preventive Medicine*
American Medical Association
American Public Health Assn*
Association of State and Territorial Health Officials*
American Foundation for Suicide Prevention*
Medscape
National Action Alliance for Suicide Prevention
National Assn of City and County Health Departments*
National Council for Suicide Prevention
National Public Health Information Coalition
Safe States Alliance*
SERMO (does DVP have a POC)
Suicide Awareness Voices of Education

Suicide Prevention Resource Center
Society for the Advancement of Violence and Injury Research (SAVIR)
**DVP Policy Network member*
CDC Grantees
National Violent Death Reporting System Directors
CORE SVIPP grantees
Injury Control and Research Centers (ICRC)
Government partners
Health and Human Services:
Assistant Secretary for Health (SG Office)
Center for Faith-Based Partnerships
Health Resources and Services Administration
Indian Health Services
National Institutes of Health – National Institute of Mental Health, NIDA
Substance Abuse and Mental Health Services Administration
Department of Defense - Defense Suicide Prevention Office
Veterans Affairs
CDC Internal Partners:
OADC
OADP
Office for State, Tribal, Local and Territorial Support
CDC MH Workgroup
Public-Private Partnerships (P3) Team
Division of Adolescent and School Health
DVP Facebook
CDC Foundation

June 5, 2018
Suicide

Abbreviated Timelines of Deliverables, 11/21/2017

Step	Deliverable	Begin at 08:00 A.M.	End by COB	Workdays	Deliver to	Comments
Analysis, Direction-setting, and MMWR Prep						
1	(1) DIRECTION AND ANALYSIS: Initial Meeting		TBD			
2	OD Planning Document/SOHCO/One Thing		DONE		RS, LS	
3	CDC/OD review of ODPD/SOHCO/One Thing		DONE			
4	Program (PGM) respond in writing to questions from CDC/OD		DONE		RS	
5	(2) MMWR: MMWR draft(non-cleared)written and sent to VS team to help guide FS development during the RT discussion only		2-Apr		RS	
6	Pre-submission CIO-cleared MMWR due to VS team		10-Apr			
7	CDC/OD(Dir, Principal Depuy Dir, OADS, OADC); CSELS (Rasmussen, Kent)review pre-submission CIO cleared and cross-cleared MMWR	11-Apr	16-Apr	4	RS	MMWR and FS will be sent to CDC/OD at the same time.
8	PGM revises, cross-clears and submits MMWR to Editors	17-Apr	25-Apr	7	MMWR Submission System, RS, LS	Max 1800 word text 250 word abstract 15 references Submit to MMWR by noon Please send VS team a comment/response matrix on how you addressed comments from Drs. Schuchat, Mac Kenzie, and Lyon-Daniel. Matrix only needed for comments from these 3 reviewers
9	MMWR edited and produced	26-Apr	9-May	10	MMWR Editors and Reviewers, PGM, RS	
10	SCIENCE CLIPS: PGM provides citations for Science Clips		21-May		RS	
11	Rich reviews citations and sends to OD/OADS and CDC librarian		22-May		Bill Thomas John Iskander Gail Bang	
Fact Sheet (Word and Graphics Versions)						
12	(3) FACT SHEET: Send FS (non-cleared) in Word (W) format to VS team		2-Apr		LS, RS	
13	Roundtable	3-April 1:30-4:30			LS, RS	
14	CIO-cleared post-RT FS(W) due to VS team	4-Apr	10-Apr	5	LS, RS	
15	CDC/OD (Dir, Principal Depuy Dir, OADS, OADC,PARP, PPEO); CSELS (Rasmussen, Kent, Royster, Martin); CDCW review CIO-cleared FS(W)	11-Apr	16-Apr	4		

16	**Pgm revises FS(W) from CDC/OD, CSELS, CDCW comments and submits revised FS(W) to VS team**	17-Apr	25-Apr	7	RS,LS	Please send VS team a comment/response matrix on how you addressed comments from Drs. Schuchat, Mac Kenzie, and Lyon-Daniel. Matrix only needed for comments from these 3 reviewers
17	**Complete internal graphic development**	26-Apr	4-May	7	LS	
18	**CDC/OD (Principal Depuy Dir, OADS, OADC); CSELS (Kent); CDCW review full-color FS(G)**	4-May	Pre-brief with Principal Deputy Director, ADS, ADC (week of 5-Feb)		RS, LS	Principal Deputy Director, ADS, ADC will provide comments on FS, PR, telebriefing script,Q&A at the pre-brief Kent, CDCW will receive courtesy copies
19	**Work days: Final edits to FS(G)**	Pre-brief with Principal Deputy Director, ADS, ADC	17-May			
20	**HHS/ASPA review and clear full-color FS(G)**	18-May	24-May	5	LS to NMB to HHS/ASPA	Send FS with Press Release through NMB
21	**CDC Locks down full-color graphic FS(G)**		24-May		LS	at 5:00pm
22	**CDC final publication preparation (English and Spanish)**	25-May	4-Jun	6	LS	LS to send English FS to Shannon Omisore for Spanish translation Holiday 28-May
Other Materials Produced						
23	**Medical Outreach Program call**		while FS is being reviewed by OD		Brandy Peaker	Program to discuss with VS potential outreach strategies for clinicians
24	**(5) TOWN HALL MEETING PREP: PGM finds 2 local demo pgms for Town Hall Mtg**		8-May		OSTLTS: Chelsea Payne, Tonya Joyner	PGM works independently with OSTLTS for this
25	**(6) PRESS RELEASE (PR) and ONE GRAPHIC: Lynn receives draft, edits it, and sends revision back to PGM**		27-Apr		PGM	
26	**Pgm revises PR**	30-Apr	4-May	5	LS, DNEM	
27	**OADC reviews PR**	7-May	11-May	5		
28	**Pgm revises PR from OADC review**	14-May	17-May	4		
29	**HHS/ASPA receives and clears PR**	18-May	24-May	5	LS	
30	**PGM OKs ASPA changes to social media materials and PR**		25-May	1	LS	
31	**Lynn, graphics, and PGM to work on "one graphic" to go with PR**	18-May	24-May	5	LS	
32	**(7) DEAR COLLEAGUE LETTER: PGM writes/clears/submits**		27-Apr		LS	CD sends to MLS for Spanish translation
33	**(8) TELEBRIEFING SCRIPT and Q&A PGM writes/clears/submits**		27-Apr		LS	SO sends English script to Belsie Gonzalez for Spanish talking points

34	**(9) CRITICAL CONTACTS and EMAIL PGM writes/clears/submits**		27-Apr		RS/LS	
Final Activities						
35	**(12) SOCIAL and ELECTRONIC MEDIA: Meet with Kamelya Hinson and PGM to go over Social and Electronic Media**		24-Apr		LS, DNEM,PGM	6 weeks prior to release; OADC to provide PGM with a social media template
36	**PGM to provide content to Kamelya Hinson; PGM works with LaKia Bryant to provide content on Digital Press Kit**		8-May		PGM, Kamelya Hinson, Arezoo Risman	4 weeks prior to release; PGM to work directly with OADC on social and electronic media. SO sends to MLS for Spanish translation
37	**(13) VS WEBSITE BUILT: PGM provides its links and alt text to LS**	25-May	31-May	4	LS, DNEM,PGM	Spanish Website also built Holiday 28-May
38	**Rich creates CDC Announcement**		29-May		Rhonda Smith	CDC Announcement released at 2pm on 6-Mar
39	**(14) PRE-BRIEFING: LS sends latest MMWR proof, FS/Graphics version, PR, Telebriefing Script, Q&A, Critical Contacts List and draft email**		4-May		LS	PGM to send all requested material by 10AM
40	**Pre-brief with Principal Deputy Director, ADS, ADC**		week of 7-May		In-person (unless traveling)	Bldg 21, 12th floor DIV: Leadership, Comm, Policy, Science SMEs Call in number provided
41	**Pre-brief with CDC Director**		week of 21-May		In-person (unless traveling)	Dir Conf Rm, Bldg 21, 12th floor DIV: Leadership, Comm, Policy, Science SMEs Call in number provided
42	**(15) NOTIFICATIONS: NPHIC call (PGM attends)**		31-May		LS, DNEM, PGM	
43	**Internal--Final materials sent to leadership and distributors**		4-Jun			Done by LS
44	**External - CDC Director sends out email to "Critical Contacts"**		5-Jun			Email should include that information is embargoed until 1pm on release date
45	**External (cont) - PGM sends email to "Critical Contacts" not otherwise contacted by CDC/OD**		5-Jun			Email should include that information is embargoed until 1pm on release date
46	**External (cont)--PGM and OSTLTS notify all other partners of impending release**		5-Jun			BRANCH: SME, Chief, Comm, Policy; Embargo in place until 1 pm
47	**(16) RELEASE Press receives materials under embargo**		5-Jun		RS, LS, DNEM	Embargo in place until 1pm
48	**CDC Director conducts telebriefing Materials released to public at 1pm**		5-Jun		TRF, LS, RS, OADC, PGM	Immediate Pre-brief 11:40; Telebrief at NOON, Dir Conf Rm, Bldg 21, 12th floor DIV: Director, Comm, Policy BRANCH: Chief, SME, Comm, Policy
49	**(17) MEDIA METRICS COLLECTED 24-hour media report due**		6-Jun		LS, DNEM	
50	**30-day Media report due**		30 days after release		LS, DNEM	
51	**(18) OSTLTS TOWN HALL PGM participates**		12-Jun		OSTLTS	SME presents overview

From: Black, Erin (CDC/ONDIEH/NCIPC)
Sent: 9 May 2018 02:41:48 -0400
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Mercy, James (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD);Kegler, Scott R. (CDC/ONDIEH/NCIPC)
Cc: Stone, Deborah (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC)
Subject: VS Pre-brief
Attachments: VS Pre-brief changes.docx, VS Pre-Brief Notes.docx

Congrats all on a great pre-brief! Anne (and Rich) even complimented us on how few changes 'compared to other pre-briefs' they had for us! Attached are my messy in-depth notes (transcripty) and also a chart of just the requested changes – please make sure I captured it as you all heard it! Also, below are some of the action items and next steps (in addition to making all the attached requested changes)!

Action Items:

- Confirm with Rich if Deb will be the SME poc at the tele-briefing
- Promote VS again after NCHS data brief
- Rich to confirm when NCHS is releasing the Data Brief
- Send terminology guidance to SG
- Ask Medscape about CME training credit
- Review the tele-briefing script to ensure the proposed headlines are the most appropriate
- Identify individuals in the states to connect reports to (re states examples)
- Crystal to cross-walk tele-brief script with the media recommendations
- Call with graphic designers to make "Be the One" bullets fit
- Propose to Schuchat's special assistant that suicide rates by age be added to the text in the MMWR intro
- Kristen to work on updating the Q&As – Tom to send the description of the increase
- Scott to draft Q&A on the big numbers and not jumping around

Next Steps:

- Revised Factsheet and Press release due **May 10** to graphic designer (have call prior)
- Changes to the tele-brief script and other comms materials by **May 14**
- Package goes to ASPA by **May 18**

-----Original Appointment-----
From: Schuchat, Anne MD (CDC/OD)
Sent: Friday, April 13, 2018 1:56 PM
To: Schuchat, Anne MD (CDC/OD); Peaker, Brandy (CDC/OPHSS/CSELS/DPHID); Schieber, Richard A. (CDC/OPHSS/CSELS/DPHID); Sokler, Lynn (CDC/OD/OADC); Omisore, Shannon L. (CDC/OD/OADC); Sorrells, Marjorie J. (CDC/OD/OCS); Simon, Thomas (CDC/ONDIEH/NCIPC); Stone, Deborah (CDC/ONDIEH/NCIPC); Mercy, James (CDC/ONDIEH/NCIPC); Crosby, Alexander (CDC/ONDIEH/NCIPC); Richmond-Crum, Malia (CDC/ONDIEH/NCIPC); Fowler, Katherine A. (CDC/ONDIEH/NCIPC); Bruce, Crystal (CDC/OPHPR/OD); Black, Erin (CDC/ONDIEH/NCIPC); Dauphin, Leslie (CDC/OD/OADLSS); Daniel, Katherine Lyon (CDC/OD/OADC); Bonds, Michelle E. (CDC/OD/OADC); Harben, Kathy (CDC/OD/OADC); Gaines-McCollom, Molly (CDC/OPHPR/DEO); Grusich, Katherina (Kate) (CDC/OD/OADC); DeNoon, Daniel

(CDC/OD/OADC) (CTR); Howe, Kristin (CDC/OCOO/OCIO/ITSO) (CTR); Corley, Ronald D. (CDC/OCOO/OCIO/ITSO) (CTR); Kegler, Scott R. (CDC/ONDIEH/NCIPC)
Subject: 1:00pm - 1:45pm Vital Signs Pre-brief: Suicide Prevention
When: Tuesday, May 8, 2018 1:00 PM-2:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: 12th Floor -- OD Suite, Conference Room 12302 (Conference Bridge: 877-985-4535, PC94833493)

Vital Signs Pre-Brief Revision Requests

Change	Reason	Requestor	MMWR	Fact Sheet	Script	Q&As
Include top 5 states (counts instead of rates)	Be careful with small numbers. Is the difference significant?	Anne				X
Clarify multiple risk factors, some can prevent but others can intervene	Since we all have life stressors, how to frame message to public on action to take when see warning signs.	Anne				X
Add note that there are multiple risk factors	Contributing factors figure – adds up to more than 100% (multiple factors and not mutually exclusive)	Anne	X	X		
Add data point on % of people who told someone they were contemplating suicide	Be mindful not to push quilt on people who feel they missed signs/opportunities. Ensure precipitating circumstances are messaged positive frame (don't normalize).	Anne			X	
Add research to confirm the contributing factors	How do we know the circumstances if they are done/deceased. What are the risk factors in the general population? Indicate that circumstances are established risk factors for suicide and other literature connects these.	Anne	X			
Add info on the study on impulsivity (24% less 5min)	How do you know if it was impulsive?	KLD				X
Add impulsivity info	Impulsivity can lead to means restriction. Focus on coping and relieving stress.	KLD				X
Acknowledge CDC employee	Recent CDC employee suicide	KLD			X	X
Is note on link to opioids in Q&A enough? Does it include chronic pain?	Lots of social media on link between suicide and opioids restriction	Anne				X
Change LE to first responders	LE feels out of place (healthcare, MH, social services, educators, LE)	Anne	X	X		
Add WHO data on other countries	How do rates compare to other countries (WHO data)? Why is it increasing here but not there (don't know but focus on contributing factors)?	Kyle				X
Add info on NVDRS expansion	Need to thank congress for the NVDRS funding.				X	
Add age-specific rates overtime and site other work (suicide rates by age group)	First question received when mentioned VS was in what age group?	Anne	X		X	

Vital Signs Pre-Brief Revision Requests

Include terminology guidance box	Suicide care is unclear as suggest care for the deceased	Anne			X	
Change suicide care to X	Suicide care is unclear as suggest care for the deceased	Anne	X	X	X	X
Add "Be the One" 5 bullets/box. Redo other graphics to make it fit.	What are the specific things that people can do that are helpful vs. harmful.	Kate		X		
Remove connect people from states can do section	States and communities are told to connect people but they don't do that people do	Anne	X	X		
Add CO example	Do we have state examples of positive suicide prevention results?	Anne				X
Add Air Force example	Do we have state examples of positive suicide prevention results?	Anne			X	
Add vet data	What percentage of increases are in veterans (have PDST)?	Anne			X	X
Confirm biggest number is on top	Data should cascade from most prevalent down.	Anne		X		
Reorganize Q&As	Q&As sometimes hard to follow and key points don't jump out. Add section for FAs.	Rich				X
Add HP 2020 goal?	Can we link to successes (HP2020) without complicating 20% by 2025.	Rich			X	

***Note: If you make the change in the Fact Sheet you MUST make the change in the MMWR**

5/8/2018 Vital Sings Pre-brief

Process (pre-meeting discussion):

- **Rich**:
  - Will get clear direction from Schuchat in 45
  - Must take verbatim notes
  - We will debrief afterwards
  - Then must make revisions within a quick deadline to get the whole package to ASPA on May 18 (but not the MMWR until its released)
  - No plans for Dr. Redfield to participate
  - Great that SG is participating (he has only done twice before)
  - Follow-up with Rich to confirm that Deb is indeed the SME for technical questions at the tele-briefing, Rich will brief her on her responsibilities, Alex can be there too but only to pass notes to Deb (Anne only wants one SME)
  - Have done 90+ vital signs
  - Great media opportunity, one hit front page of NYTimes with a 4 column picture, usually elicits 600-750 media stories (Zika hit 1700), this media would cost $1m+ - varies on other things in the media, Schuchat will help focus the media
  - Townhall the week after
  - All calls should go to the CDC OD Media Office
- **Rich: Why are the rates going up? Is it political?**

Pre-brief

Introductions:

- **OD:** Anne Schuchat, Brandy Peaker, Rich Schieber, Shannon Omisore, Katherine Lyon Daniels, Kate Grusich, Molly Gaines-McCollom, Dan DeNoon, Kate Galatas, Kyle McGowan
- **DVP:** Tom, Jim, Katie, Crystal, Erin, Alex, Asha +Scott

- **Tom:**
  - Thanks Anne and VS office for your support and for making this happen we are very excited for this great opportunity
  - Deb sends her regrets, she had a death in the family, was very excited about this opportunity to raise awareness as a preventable PH problem
  - Suicide is the 10th leading cause death and alarmingly increasing
  - Existing prevention activities focus on identifying and treating MH problems
  - Released suicide TP last year with prevention opportunities
  - This VS is the first analysis of state specific suicide trends and NVDRS circumstances
  - It prioritizes suicide prevention and broadens the perspective of options
  - 45k suicides in 2016, 1999-2016 state increases, ND 58% increase, overall more than 30% in 25 states
  - NV only state didn't have an increase but consistently high rates 2016 ranked 9th highest
  - NVDRS used data 27 states – more than half didn't have MH problem
  - Other circumstances are very common (physical health and jobs/financial) didn't differ
  - Other more common relationship problems, IP and conflicts, stress – criminal, legal, eviction, crisis higher in those without MH problems but common among those with MH problems too
  - State specific trends highlight the importance of suicide prevention in states and communities
  - Included state ranking table – editors requested we move to the stack with one click
  - Help states see their stance and motivate action and local and national media
  - Point to a range of opportunities – comprehensive public health approach – attention to TP examples of specific activities for groups and warning signs and media recommendations
  - State trends and contributing factors and prevention strategies raise awareness and motivate action
- **Anne:**

- Thanks for all the work – state specific and overall national increase will get lots of attention and we can use for maximum good
- **Minor: Please be careful with the small numbers. Is it really different from other changes? You mentioned ND large increase (58%) but what is it the percentage or rate, absolute or relative? It went from 2 to 6 for the overall percent. What was the difference in numbers, was it really huge?** Don't include ND in the tele-brief script –aren't they the only state that didn't have a recession?
  - **Tom:** It includes the absolute and relative increase and model annual percent change – it's a test of statistical significance. It's a 51.6% change in ND 13.3 to 20.9 is an increase of 6.9 per 100k.
  - **Kristen**– ex. number suicides was 50 and went up to 100 – it doubled but its only 50 people – include counts for top 5 states
- **Substantive**: In the analysis you did a lot to compare MH to those without MH problems – talked about triggers and preceding events. But these could be common to others who aren't suicidal – who have family, communities, friends supporting them. Can we prevent the triggers, no, so how can we frame the media messages since we all have life stressors? For example, we say here are warning signs so we need to make it more actionable for the general population.
  - **Tom:** For the contributing circumstance the NVDRS system captures circumstances believed to contribute to suicide – in terms of the Fact Sheet ways to understand some circumstances can prevent but others intervene to help them cope – resiliency and coping skills.
  - **Alex:** Interaction of multiple risk factors – not one reason – divorce, substance abuse, financial problems, interaction of multiple factors. Technical package talks about how to promote resiliency and coping and find help to develop connectedness and social support.
- These questions are to help shape the press release and tele-brief to shape intended messages. I had commented on the figure of the factors that contribute – and to order by frequency ex. loss of housing only 4%. Add a note that it adds up to more than 100% because people have multiple factors.
- People have a loved one who died they might have a lot of quilt about what they missed or what they didn't do. We need to be transparent that many people have multiple contributing factors and be mindful not to push quilt on people and not to encourage second guessing. It's not cause and effect its timing – have to go backwards – we are only talking about completed suicides. But how do you know the circumstances since they are gone? It will be good but I want to control the message – relationship problem 42% but what percentage of the U.S. population have relationship problems? If our goal is to focus on prevention. Data limitation is legitimate but build on the literature than just NVDRS if our focus is more than MH – this is suicide of people like me – what am I missing in my family – don't want to get a lot of worried well.
  - **Tom**: Deemphasize not that they occurred but that the suicide was attributed to these circumstances. We interview family/friends by LE and coroner and ME. There is a limitation in data because of tracking suicide preventions. We have and can add other research to confirm these factors. We recommend to look for these risk factors for a reason.
  - **Katie:** This information comes from ME, LE, and corners based on interviews with loved ones or others that knew them. They think this played a part.

- **KLD**:
  - When there is not a known MH issues then interpret as impulsive acts. How do you know if it was impulsive? We don't know if they were considering for a long time. We don't know what they were thinking. Someone described it that way as impulsive.
    - **Tom:** Impulsivity is a real phenomenon - there is a study of people who survived nearly lethal attempts – 24% reported after their attempt less than 5 min
    - **Kristen**: Put them at greater risk
  - If the media talks in that way (impulsivity) it turns into a removal of lethal means issue. Close to half are impulsive so who should have access to any kind of means. I don't want it to be overly politicized. We must be very specific in how we talk about what we know – and focus on the ways to help anyone learn to cope and relive stress when you know they are stressed.

- At CDC we had a recent issue with a suicide and people did not know what was going on or recognize the symptoms. Are we doing this issue because of that event? NO – but it will be discussed that way. It could turn into something personal about an individual a CDC employee.

- **Anne**:
  - In addition to CDC employee – a lot of social media about chronic pain and opioids and driven to suicide because they are in pain is so bad and think they can't get medicine – or they a have substance abuse or physical problem. Add to Q&A how we will handle that – is it political?
    - **TOM**: Included in the Q&As and pulled from opioids TP - let us know if it doesn't address the question.
  - Draft tele-brief script. It talks about partners including sectors (healthcare, MH, social services, LE, educators). **Why LE?** It looks like it was in the wrong place there are multiple high risk populations.
    - **Alex:** LE is a data source, NVDRS, LE data is one of three primary sources. Many cases LE are first to respond to death. In some cases they provide some data. Also, there is an increased risk among first responders. LE interventions specific to that population because of increased risk in that occupation – we worked with LE because they are the responders to 911 to prevent the suicide. Change LE to first responders

- **Kyle**:
  - How do these rates compare to other countries? We will get this question.
    - **Tom**: WHO online access to their suicide rates and data for 2000-2015– globally suicide rates have gone down slightly – China, Japan and India with high rates are decreasing Canada's are flat.
    - **Alex**: A few European countries were high during the recession but they have come down and we (U.S.) haven't
  - Why are we increasing but that isn't happening in other countries? **Anne**: We will be asked to speculate.
    - **Tom:** We get that question a lot. The nature of data sources is that it is great to understand trends and outcomes but not the contributing factors and it's rarely caused by one factor but many (family, relationships, finances). Economic conditions and the link to suicide – role of great recession and subsequent financial challenges. More research look at association of suicide rates and economic conditions. And link to the opioids epidemic – in the past explained as increased availability and misuse led to increase use – it's an increased risk factor.
  - If it tracks along with the economic recession and increase during great recession but now economy is better haven't seen a drop – why?
    - **Tom:** Tried to point to those to potential explanations/reasons for increases might not be understand we do know a lot about the contributing factors link to NVDRS and suicide prevention.
  - Briefly mention expansion of NVDRS – pretty big deal – now have coverage for all 50 states PR and DC push home the fact that we have the expansion – better data moving forward – thank you for getting us the funds to do that – work that into the tele-brief script

- **Anne:**
  - Include in the MMWR can we add the age-specific rates over time – everyone wants to know that – up in teens –was focus on teens, veterans, middle-aged people even if not primary focus need the specific result. Don't need age specific trend by state but just over all results. The first question I got was what age is it going up in? 20k in 2015 alone – if compared baseline and end group – have female and male overtime its gone up in both groups – **can you add a line in text about stratify by age groups**? Australia 104 yr old going to Swiss for suicide. MMWR page 1 rates increase in all age groups from x percent to Y percent in age group since we have the whole technical package to point to.
    - **Tom**: Didn't carry it through analysis because we and NCHS already has done a lot -- in an earlier version we had the NVDRS distribution Table 2 for the 27 states in NVDRS – its only for 2015 not the rate of change. It went up in all for the national – NCHS data brief – for the most part except very old. There is other work we can site – increases across the lifespan except 74

        - NCHS is doing a quick stat on youth homicide and suicide trends better the following week – and NCHS data brief postponed after vital signs age and method – Rich to confirm
    - Terminology – what is the word for suicide vs attempt – what can health care providers do – train staff in suicide care – what does that mean? Sounds like they already died. Is it too late to do care? Please include terminology in the tele-brief script
        - **Alex:** MH care – it is dealing with those that have nonfatal suicide behavior and ideation
        - **Tom**: We developed guidance on terminology– helpful don't say successful suicide -- it has to be clear and non-jargoning so build it in there
- **Give Dr. Adams the content for how to talk about suicide and ask him to focus on talking to Drs. Great opportunity for him to get up to speed.**
    - Alex: We did a Medscape recording– they can do CME training
- **Kate**
    - What can 'everyone' do more specifically – we have on Factsheet back page and tele-briefing script- when it gets to everyone can – know early warning sign, identify and connect, etc., is there an opportunity to get more specific – what can I do? What are those specific things that are helpful vs what is not helpful. Fine line with guilt – five minutes of time – in the moment trying to know the right thing to do – know these work better – highlight those. Article talk about terrible problem and warning signs – well what could I do – not sensationalize and scary versus empowering. **Anne:** media LOVE the public focus – they will put a box in the data.
        - **Tom:** We can add "be the one" and they have five steps – hard with the space –
    - **Anne:** states and communities are told to connect people but they don't do that -- move to individuals - purpose of vital signs is to get to media and get public to act
        - **Alex:** Data focus in on what's happening in the states so focused on what states and communities can do
    - Is there an uptake in states with physician assisted suicide?
        - **Alex:** OR and WA – those people die it is listed as the natural cause so hard to track ex. terminal lung cancer – listed on death certificate as terminal cancer – so undetected – not a lot in OR data
    - Tele-bring script – desired headline working with media and how to frame – what we want the headlines to be – make sure our headlines and their headlines (already lots on the numbers) what do we want the other headlines to be and it changes what we que up for the tele-briefing – focus on that
- **Anne**
    - CO is doing everything they can – is there a state example we can use – positive results – what might happen if we did everything
        - **Jim:** Air Force is doing a comprehensive suicide plan and saw significant reductions **Anne:** Helpful in advance to have a couple individuals who know that can refer reporters to the positives –
    - What percentage of these increases a in veterans and PDST – does the VA have a program reach to Action Alliance and know in advance –
    - When NCHS comes out we can amplify VS at that point too.
- **Ann:** We will be really go! Its great – you don't have that much to change compared to others
- **Kyle:** Q&As are really good!

Debrief

- **Rich:** They don't go much better than that! Very well done!
    - Make sure any changes to Fact Sheet are also made in the MMWR
    - Add Air Force as a positive example tele-brief script –- and CO in the Q&As
    - Add Suicide rates by age group by year of event – in the intro of MMWR summaries the trends MMWR page 1 rates increase in all age groups from x percent in age a-b to Y percent in c-d – Get clarification/propose to add to results (table) or sentence in intro - graph is the map
    - Precipitating circumstances – make sure our message was correct for families who lost a loved one – don't compound guilt

- Adds to more than 100% - add text that experience multiple – complex "multiple factors and not mutually exclusive" Add disclaimer
- Biggest number is on top – cascade from most prevalent down – we already addressed it
- Include everyone can and work the "Be the one" five bullets – take 3 TP bullets out and stick in the five – take out the lifeline and warning signs since have a box –move connecting people in community to people can – work the five into the be the one to – start with the short one – everyone can – start with five bullets – access to methods – Add back Be the One to
- **Q&A**
  - What is happening in 50 states – add to Q&A?
  - Number for low population states – top five 10 high rank states – 99-16
  - Guilt issue – part of tele-briefing script messaging – say even those that weren't diagnosed with MH problem – these are problems people deal with every day and help people cope with problems they experience everyday many people – don't imply or suggest don't normalize it learning to deal with resiliency and coping– Katie have a data point on percentage of people who told someone they are thinking about suicide – many didn't express suicidal thoughts – scientifically interested in MH vs nonMH how do we do better for both populations – everyone problem because everyone deals with these – people to people interactions help Media go to guns - way to avert is many people deal with these factors – actions can be good for the general population in coping with life challenges – Add Q&A section on guns-gun mechanism in less than half and have other mechanism
  - What are the risk factor proportions in the general population vs those that killed themselves – what was proportion non-completed – Jim's point in appropriate place we can indicate that these circumstance are established risk factors for suicide and other literature that connects those – risk among those with or without – add to the Q&As
  - International comparisons – Add to Q&As – why in US vs other places -
  - Rich – organize Q&As so it so it jumps out at her – organize with headings – how it was presenting – data isn't great, multiple factors, economic conditions and opioids misuse but what we do know is the contribution circumstances and those factors we can focus on – we can pull into a heading and put on the front page – order questions in Q&As put that at the top
  - Pg 7&8 opioids and chronic pain
  - LE – change to LE to first responders – change add
  - Was it Impulsive – add to Q&A – 5 minutes form think to do – she connected the dots – without MH problems are impulsive than reduce access to lethal means doesn't work for everyone – all 54% who didn't have MH they are not all impulsive suicide and thought about it for a while and had a lot of factors that contributed - 24% said less than five minutes and the flip is revers 76% -ideation comes and goes but when they decided they just did it – impulsivity is separate from MH and NONMH connects with pint about circumstances are things that many experience everyday
  - Tele-briefing script – expansion of NVDRS to PR and DC – thank you Washington – time course or known plans – when to start – hit the last state – what year data will be out Included a healthy people 200 objective and this will allow us to meet that goal and excited to make this available t all 50 states
  - SG and Dr. Schuchat need to have a list of bad word – guidance – add good words to tele-briefing not successful suicide – box – add a box – not commit or successful – send glossary to SG –
  - Suggest headlines – on press release – Kate – we don't need the numbers focus on in box on tele-briefing script – rethink these headlines –OADC generated these – make sure these are the ones we want them to use – Crystal cross walk with the media recommendation
  - Suicide care – can we say something else – page 5 of the tele-briefing – put clinical guidelines in the sentence of tele-brief script – care for those at risk
  - Press referral for AA, CO and Air force – list of our people we will call – lined up on someone to take calls – press contacts make sure we have the contacts

- Q&A – vet, PTSD, multiple deployments – just got them today so will add – asked about proportions of the increase that is attributed to Vets – vets and military and lumped together
- Page 3 of tele-briefing fourth bullet – expand and awareness – reduce annual suicide rate by 20% by 2025 – add here the 2020 success – reached a goal - confused by two things and two numbers – suggested Tom 2020 – Katie we are excited to make fudging available – doesn't committee us to anything
- Fact Sheet
    - Add those five things page 3 bottom is so clear with warning signs and top is hard to read and memorize – if those five things are that important – taking out the big block and put a simpler message in for the five things Tom – the content is very important we provided a similar image – it's meant for inspiration – comms folks have suggestions to improve –figure – too much text have a call with the graphics designer – cut out some of the text – make graphic similar and split top 2 thirds side by side and do the five points to jump out – move bottom graphic over and fit in the 5 bullets – take a look at page 3 – high priority
    - Acknowledge CDC employee
    - Put counts instead of rates – on the Q&A for top 5 rates –
    - Go to ASPA on May 18th COB – 5:10 COB revised by fact sheet and press release by COB on May 10th Thursday to go to the graphic artist – will have a call before then fact sheet with the stickies – want to give our center an opportunity to weigh in to see what we are recommending – quick turn around can't get their input –
    - May 11 Friday – go to creative – back Mon/Tues for last review before HHS – at same time send VS team a copy – program go through Shannon NMB
    - CON May 14th – need changes to tele-briefing script and other comms materials – including the Q&Q
    - Going up in all age groups except 75adn older – range of increase – based the statement on our own study data - mostly suffocation – AI/AN – does he want in the MMWR or tele-briefing – went with intro back 99-15 – already say the other ethnicity and add across age groups – add to that sentence in the intro reference already covers it and add to the FAQ list more details
    - Five least populated minimum count of suicide was – 2 below 20 that was it per aggregated period – all others are bigger
    - ND – in paper say increase ranges from 6% in X to 58% in ND –address in the A&A that in no case was there fewer than 20 and states in smaller pop by aggregating data in 3 year intervals able to have the case counts – pick out the small populations states – smaller pop states –so we aren't repeating the NCHS data brief – WY had biggest absolute rate increase
    - Kristen do Q&A – Tom send description of increase –
    - Be the one to – Scott- draft Q&A why we are seeing the big numbers and not jumping around
    - Columns MMWR Fact Sheet Q&A Fact Sheet and changes – age change in MMWR but also in the Q&A then assign names -

From: Iverson, Dontae (CDC/OD/OADC)
Sent: 23 Feb 2018 16:35:43 -0500
To: Adams, William (Joe) (CDC/OPHPR/DSLR);Allende, Taka (ATSDR/OCOM/HCT);Alvarez, Cindy (CDC/OPHSS/CSELS/DSEPD);Alvey, Robert (CDC/OPHPR/DEO);Alvin, Lorrie (CDC/OID/NCHHSTP);Anderton, John (CDC/OPHPR/OD);Asbury, Karla (CDC/OID/NCIRD) (CTR);Auerbach, John (CDC/OD/OADP);Awsumb, Brian (CDC/OCOO/FMO);Baden, Dan (CDC/CGH/DGHT);Baden, David (CDC/OCOO/OFR);Baker, Duiona R. (CDC/OSTLTS/OD);Bart, Sandra (Sandy) (CDC/OD/OADP) (CTR);Bauer, Ursula (CDC/ONDIEH/NCCDPHP);Beauvais, Denise (CDC/OID/NCIRD);Bell, Beth (CDC/OID/NCEZID);Bellinger, Laura (CDC/CGH/OD);Berger, Sherri (CDC/OCOO/OD);Berryman, Laurel (CDC/ONDIEH/NCBDDD) (CTR);Black, Erin (CDC/ONDIEH/NCIPC);Blankenship, Anita (CDC/ONDIEH/NCCDPHP);Blocker, Tanya (CDC/OD/OADP);Blosser, Fred (CDC/NIOSH/OD);Boedigheimer, Steven F. (CDC/OPHPR/DSLR);Bonds, Michelle E. (CDC/OD/OADC);Bonzo, Sandra E. (CDC/ONDIEH/OD);Boyle, Coleen (CDC/ONDIEH/NCBDDD);Breedlove, Byron (CDC/OID/NCEZID);Briss, Peter (CDC/ONDIEH/NCCDPHP);Brown, Renee (CDC/ONDIEH/NCCDPHP);Bruner, Erin (CDC/OCOO/HRO);Brusuelas, Kristin (CDC/OD/OADP);Bryant, Nancy (CDC/OID/NCHHSTP);Buckner, Amesheia (CDC/OD/OADC);Burkhardt, Ann (CDC/OID/NCEZID);Butler, Terry (CDC/OID/NCHHSTP);Byers, Mark E. (CDC/OCOO/OFR/OA);Cagle, Chris (CDC/OID/NCHHSTP);Canada, Michelle (CDC/ONDIEH/NCIPC);Canaday, Autumn (CDC/OD/OADC) (CTR);Cope, Carolina (CDC/OD/OADC) (CTR);Cardo, Denise M. MD (CDC/OID/NCEZID);Carmichael, Callie (CDC/OD/OADC) (CTR);CDC OADC CDC Connects;CDC OADC Division of Public Affairs All;CDC OD OADC *Emp;CDC OD OADC ADCS;CDC OD OADC DPA OD *Non-Emp;CDC Social Media Council;CDC Web CDCgov Features Workgroup;CDC Global News;Chaney, Sascha (CDC/ONDIEH/NCBDDD);Ciccarone, Rachel (CDC/OD/OADC);Clark, Cynthia K. (CDC/OD/OCS);Cochi, Steve (CDC/CGH/GID);Coffin, Nicole (CDC/OID/NCEZID);Cole, Galen (CDC/ONDIEH/NCCDPHP);Coleman, Sharon R. (CDC/OD/OMHHE);Colleen Murphy;Collins, Janet L. (CDC/OD/OADPG);Colson, Angela S. (CDC/ONDIEH/NCBDDD);Cox, Christopher M. (CDC/OID/NCEZID);Cox, Joanne D. (CDC/OPHPR/DEO);Cramer, Emily (CDC/OID/NCIRD);Creel, Stephanie (CDC/ONDIEH/NCCDPHP);Crick, Cynthia (CDC/ONDIEH/NCCDPHP);Cudmore, Dana (CDC/OID/NCEZID);Daigle, David (CDC/OID/NCEZID);Daniel, Katherine Lyon (CDC/OD/OADC);Das, Mansi S. (CDC/OD/OADC);De Vallescar, Eva (CDC/OSTLTS/OD);DeCock, Kevin (CDC/CGH/DGHT);Degutis, Linda (CDC/ONDIEH/NCIPC);DeLuca, Nick (CDC/CGH/OD);Diaz, Shelly S. (CDC/OID/NCHHSTP);Dobbs, Ashante M. (CDC/OD/OADC);Dorigo, Leslie (CDC/ONDIEH/NCIPC);Dorsey-Bowman, Christine (CDC/OSTLTS/DPHPI);Duckworth, Melanie A. (CDC/OD/OMHHE);Dudley, Amanda (Aldridge) (CDC/ONDIEH/NCBDDD);Durden, Teresa (ATSDR/DCHI/OD);Eisenberg, Emily (CDC/OID/NCIRD);EOC Report (CDC);Bruner, Erin (CDC/OCOO/HRO);Erlwein, Roberta (CDC/OSTLTS/DPHPI);Eschelbach, Julie (CDC/ONDIEH/NCIPC);Ethier, Kathleen (CDC/OID/NCHHSTP);Falk, Henry (CDC/ONDIEH/OD) (CTR);Foote, Darlene (CDC/OID/NCHHSTP);Forsythe, Ann (CDC/OID/NCHHSTP);Fowler, Tony (CDC/OID/NCIRD) (CTR);Fridinger, Fred (CDC/OD/OADC);Galatas, Kate (CDC/OD/OADC);Gibbs-Scharf, Lynn (CDC/OCOO/OFR);Giddens, Jamey S. (CDC/OPHSS/CSELS/DPHID);Gilbertz, Pamela (CDC/ONDIEH/NCCDPHP);Gonzalez, Camille L. (CDC/OCOO/OFR/OA);Grant, Llelwyn (CDC/OD/OADC);Grant, Tanikqua (CDC/OD/OADC);Greaser, Jennifer (CDC/OD/CDCWO);Green, Yvonne (CDC/OD/OADPG);Haddix, Anne (CDC/ONDIEH/NCCDPHP);Hammond, Shelley S. (CDC/ONDIEH/NCCDPHP);Hanlon, Kelly (CDC/ONDIEH/NCCDPHP) (CTR);Harben, Kathy (CDC/OD/OADC);Harden, Camille (CDC/ONDIEH/NCBDDD);Hearn, Thomas L. (CDC/OID/NCEZID);Heldman, Amy B. (CDC/OD/OADC);Henderson, Joseph (CDC/OCOO/OSSAM);Hickman, Gayle J. (CDC/OD/OCS);Hines, Sarah Nicole (CDC/OD/OADC);Holmes, Wendy (CDC/OSTLTS/OD);Horvath, Jennifer R. (CDC/OPHPR/DSAT);Hoskins, Sharon (K.D.) (CDC/OD/OADC);Howard, John (CDC/NIOSH/OD);Hunter, Edward L. (CDC/OD/OADP);Ikeda, Robin

(CDC/ONDIEH/OD);Ingraham, Tracy (CDC/OID/NCHHSTP);Iverson, Dontae (CDC/OD/OADC);Jaffe, Harold W. (CDC/OD/OADS);James, Jerrell (CDC/OID/NCEZID);Johnson, Alison (CDC/CGH/DGHP);Johnson, Linda (CDC/OID/OD);Johnson, Rachel (CDC/CGH/DGHP);Joiner, Shane (CDC/ONDIEH/NCCDPHP) (CTR);Jones, Jamila H. (CDC/OPHSS/CSELS/DPHID);Jones, Rasaan (CDC/OCOO/OSSAM);Jones, Tameka (CDC/OCOO/HRO);Katsoyannis, Miranda (CDC/OD/CDCWO);Kent, Charlotte (CDC/OPHSS/CSELS/DPHID);Kenyon, Thomas A. (CDC/CGH/OD);Khabbaz, Rima (CDC/OID/NCEZID);Khan, Ali S. (CDC/OPHPR/OD);Kicera, Tamara J. (CDC/OD/OADPG);Knutson, Donna (CDC/ONDIEH/NCEH);Laird, Susan (CDC/OD/OADC);Lampasona, Alexa (CDC/OD/OADC) (CTR);Lancashire, Jeffrey H. (CDC/OPHSS/NCHS);Liburd, Leandris C. (CDC/OD/OMHHE);London, Joel (CDC/ONDIEH/NCCDPHP);Lubar, Debra (CDC/OID/NCEZID);Lubell, Keri M. (CDC/OPHPR/DEO);Lum, Max (CDC/NIOSH/OD) (CTR);Martin, Laura Yerdon (CDC/OPHSS/CSELS/OD);McClellan, Marcie (CDC/OID/NCHHSTP) (CTR);McCraw, H. Mac (CDC/OPHSS/NCHS);McKenna, Jeffrey (CDC/ONDIEH/NCCDPHP);Mebane, Reggie (CDC/OD/OEEO);Meinhardt, Ted J. (CDC/ONDIEH/NCEH);Mendizabal, Jose (CDC/OD/OADC);Mermin, Jonathan (CDC/OID/NCHHSTP);Miles, John R. (CDC/ONDIEH/NCBDDD) (CTR);Mink, Jenna Leann (CDC/OID/NCEZID);Minor, Anniece (CDC/ONDIEH/NCCDPHP);Mitchell, Betsy (CDC/ONDIEH/NCBDDD);Monroe, Judith A. (CDC/OD/OCS);Moran, Belen (CDC/CGH/OD);Moseley, Robin (CDC/OID/OD);Myers, Brad (CDC/OD/OADC);Peeples, Amy B. (CDC/ONDIEH/NCIPC);Pitts, Dana L. (CDC/OPHSS/OD);Powell, Rachel (CDC/OID/NCHHSTP);Scott-Morgan, Tina (CDC/OD/OADC);Siegel, Vivi (CDC/ONDIEH/NCEH);Biagioni, Mark T. (ATSDR/DCHI/OD);Brown, Y. Teresa (CDC/OPHSS/CSELS/DPHID);Cosgrove, James (CDC/OD/OADC);Flynn, Paige (CDC/OD/OCS);Guest, Megan (CDC/OD/OADC);Hoffmann, Candice (CDC/OID/NCEZID);Kelly, Bertram (CDC/OD/OADC);Koelker Wolfe, Ellery Rose (CDC/OID/NCIRD);Levinson, Kate (CDC/OID/NCEZID);Newell, Monica (CDC/OD/OADC);Nguyen, Von (CDC/OD/OADP);Nicholls, Sandra N. (CDC/OPHPR/DSNS);Nichols, Bill (CDC/OCOO/PGO);Noel, David (CDC/OD/OADC);Nordlund, Kristen (CDC/OID/NCIRD);Northen, Laura N. (CDC/OD/OADC);Nunnally, Tammy (CDC/OID/NCHHSTP);Nuriddin, Azizeh (CDC/OD/PPEO);OConnor, John (CDC/OID/NCEZID);Olivares, Dagny (CDC/OSTLTS/OD);Payne, Chelsea C. (CDC/OSTLTS/OD);Pearson, Christine (CDC/OID/NCEZID);Petty, Jacqueline (CDC/CGH/DGHT);Phoenix Weir, Ursula (CDC/ONDIEH/NCBDDD);Pietz, Harald (CDC/OPHPR/DSLR);Popovic, Tanja (CDC/OD/OADS);Prue, Christine (CDC/OID/NCEZID);Quartarone, Richard (CDC/OID/NCIRD);Resha, Karen (CDC/OID/NCHHSTP);Reynolds, Barbara S. (CDC/OD/OADC);Reynolds, Matthew (CDC/ONDIEH/NCCDPHP);Risman, Arezoo (CDC/OCOO/OSSAM);Robinson, Susan (CDC/OID/NCHHSTP);Roebuck, Von (CDC/ONDIEH/NCEH);Ross, Laura (CDC/OD/OMHHE);Rowland, Amy (CDC/CGH/OD);Sage, Michael J. (CDC/ONDIEH/NCEH);Saltmarsh, Nancy (CDC/ONDIEH/NCCDPHP);Johnson, Margaret Sarti (CDC/ONDIEH/NCCDPHP);Schuchat, Anne MD (CDC/OD);Seneca, Dean (CDC/OSTLTS/OD);Sewell, Jenny (CDC/OCOO/OFR/OA);Shaw, Frederic (CDC/OPHSS/CSELS/OD);Sheedy, Kristine (CDC/OID/NCIRD);Shepherd, Charles E. (CDC/OPHSS/CSELS/OD);Shriber, Donald E. (CDC/CGH/OD);Simon, Gia M. (CDC/OSTLTS/OD);Singh, Natasha (CDC/ONDIEH/NCBDDD);Skinner, Bryon (CDC/OD/OADC);Smith, Jill (CDC/OID/NCEZID);Smith, Joseph (CDC/ONDIEH/NCBDDD);Sokler, Lynn (CDC/OD/OADC);Sondik, Edward J. Dr. (CDC/OPHSS/NCHS);Sosin, Dan (CDC/OPHPR/OD);Spencer, Lorine M. (CDC/OSTLTS/OD);Spilker, Brittney A. (CDC/OD/OADC);Stanojevich, Joel G. (CDC/CGH/OD);Stein, Joanne L. (CDC/CGH/DGHP) (CTR);Stephens, James W. (ATSDR/DTHHS/OD);Stover, Beth (CDC/OSELS/SEPDPO);Summers, Arianna E. (CDC/ONDIEH/NCCDPHP) (CTR);Swensen, Sue (CDC/OPHSS/CSELS/DHIS);Swerdlow, David (CDC/OID/NCIRD);Telfer, Jana L. (CDC/ONDIEH/NCEH);Tenenbaum, Jordan (CDC/OCOO/OFR/OA);Thapar, Preeti (CDC/OD/OADC) (CTR);Thomas, Larry W. (CDC/OD/OADC);Toomer, Diana (CDC/OD/OADC);Toomey, Kathleen (CDC/CGH/DGHA);Turner, John H. (CDC/OPHPR/DEO);Vanderford, Marsha L. (CDC/CGH/OD);Vandiver, Kay Phillips (CDC/ONDIEH/NCCDPHP);Howgate, James (CDC/OD/OADP);Walker, Michelle (CDC/OD/OADC);Walsh,

Michele S. (CDC/ONDIEH/NCCDPHP);Ward-Cameron, Conne (CDC/OPHSS/CSELS/DPHID);Ware, Belinda (CDC/OD/OADC);Waters, Tinsley (CDC/ONDIEH/NCIPC);Westbrook, Kyresa (CDC/OD/OADC);Wharton, Melinda (CDC/OID/NCIRD);Wiley, Sarah D. (CDC/OID/OD);Wilkinson, Kelly (CDC/OSTLTS/OD) (CTR);Williams, Alesia S. (CDC/OPHPR/OD);Williams, Kymber (CDC/OID/NCHHSTP);Williams, Teresa (CDC/OD/OCS);Williams, Walter W. (CDC/OID/NCIRD);Wilson, Esther (CDC/OD/OADC);Wilson, Michelle (CDC/OCOO/OFR/OA);Winogradsky, Janis (CDC/ONDIEH/NCCDPHP);Wooddall, Andrea (CDC/OSTLTS/OD);Zeigler, Sara (CDC/OID/NCHHSTP);Puddy, Richard (CDC/OD/OADP);Kellogg, Marisa (CDC/OD/OADC)

Subject: Weekly Media Update February 23, 2018

Below are several items that CDC's Division of Public Affairs is aware of that have received national and/or significant local media or social media attention during this past week, or are likely to receive attention in the coming week.

Website section views Mon – Thurs: 181, 385

Top news items this week:

1. CDC seeks new labs for bioterror pathogens to replace aging facility – The Washington Post
2. Flu Killed 13 Children Last Week But May Be Winding Down, CDC Says – TIME
3. Missing CDC employee left work sick 10 days ago, hasn't been seen since, police say – ABC News

In The Past Week: News Media - February 12, February 16, 2018

Urban-Rural County and State Differences in Chronic Obstructive Pulmonary Disease — United States, 2015

Wednesday, February 21, 2018, an article in *MMWR* explained howCDC analyzed 2015 data from the Behavioral Risk Factor Surveillance System, Medicare hospital records, and death certificate data from the National Vital Statistics System to assess urban-rural variations in prevalence, hospitalizations, and mortality; obtain county-level estimates; and update state-level variations in COPD measures.

HIV Diagnoses Among Persons Aged 13–29 Years — United States, 2010–2014

Wednesday, February 21, 2018, an article in *MMWR* detailed the rates of HIV infections between persons aged 13 – 29 years and how CDC analyzed data from the National HIV Surveillance System (NHSS) using narrow age groups to better understand HIV infection among adolescents aged 13–19 years and young adults aged 20–29 years in the United States and identify ideal ages to target primary HIV prevention efforts.

Prevalence of Amyotrophic Lateral Sclerosis — United States, 2014

Wednesday, February 21, 2018, an article in *MMWR* explained how this report updates the initial National ALS Registry findings regarding ALS prevalence for the period January 1, 2012–December 31, 2013, and presents new findings for 2014 and, for the first time, includes Medicare hospice data and ALS prevalence rates by census region.

Prevalence of Self-Reported Hypertension and Antihypertensive Medication Use Among Adults Aged ≥18 Years — United States, 2011–2015

Wednesday, February 21, 2018, an article in *MMWR* detailed discuss the prevalence of hypertension across different demographics using data from the Behavioral Risk Factor Surveillance System. Persistent differences were observed by age, sex, race/ethnicity, level of education, and state of residence.

Advice and Action to Reduce Dietary Sodium Among Adults With and Without Hypertension—Behavioral Risk Factor Surveillance System, 2015

Wednesday, February 21, 2018, an article in *MMWR* detailed data from 50,576 participants in the sodium module of the 2015 Behavioral Risk Factor Surveillance System in nine states and Puerto Rico were analyzed to determine the prevalence of reported sodium reduction advice and action among participants with and without self-reported hypertension.

In The Week Ahead: News Media - February 20, February 23, 2018

Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 states, 2003–2014

Wednesday, February 28, 2018, an article in *MMWR* will detail the data collected from 2003 to 2014 that were analyzed by comparing differences in suicide characteristics and circumstances between AI/AN and white decedents.

CDC Grand Rounds: Promoting Hearing Health Across the Lifespan

Wednesday, February 28, 2018, an article in *MMWR* will explain how loud noises can cause permanent hearing loss through metabolic exhaustion or mechanical destruction of the sensory cells within the cochlea.

Trichinellosis Outbreak Linked to Consumption of Privately Raised Raw Boar Meat — California, 2017

Wednesday, February 28, 2018, an article in *MMWR* will detail the account of a trichinellosis outbreak that came from a domesticated wild boar raised and slaughtered on a private family farm in northern California.

Rabies Vaccine Hesitancy and Deaths Among Pregnant and Breastfeeding Women — Vietnam, 2015–2016

Wednesday, February 28, 2018, an article in *MMWR* will detail howMinistry of Health found that, during 2015–2016, two probable cases of rabies were reported in breastfeeding mothers and four in pregnant women, all of whom had been bitten by dogs. These findings highlight the need for public health messaging about the safety and effectiveness of postexposure prophylaxis in preventing rabies among all persons with exposures, including pregnant and breastfeeding women.

Progress Toward Poliomyelitis Eradication — Nigeria, January–December 2017

Wednesday, February 28, 2018, an article in *MMWR* will describe the progress in polio eradication activities in Nigeria during January 2016–December 2017 and will update previous reports.

Tentative Topics to be promoted on CDC's primary social media channels and Web* - February 26 – March 4

Social Media Lineup – Week of 2/26/2018

** Pending program edits/content

Monday 2/26

Public Health Grand Rounds
Epi Elective
CDC Learning Connection
Evaluation Fellowship

Handwashing Repost
NMI Notes

Tuesday 2/27

Antibiotic Awareness
Flu
HPV Vaccine
We Were There
Flu Repost
Population Health Training in Place Program
National Electronic Disease Surveillance System Base System (NBS)
Rare Disease Day

Wednesday 2/28

Sepsis
TBI Report
Antibiotic Stewardship Course
ALS Registry
Workplace Health
National Notifiable Diseases Surveillance System (NNDSS)
Blood Disorder Webinar
Rare Disease Day

Thursday 3/1

CDC Science Ambassador
We Were There
Flu
Learning Connection Repost
CDC in the Field
Population Health Training in Place Program
MMWR
Biosecurity of Birds Twitter Chat

Friday 3/2

HIV Testing
Bring Your Brave
EID
Oscars Food Safety
Underthelens
Flu Telebriefing
Outbreak Response Training Program

Saturday 3/3

World Hearing Loss Day
Oscars Food Safety

Sunday 3/4

Oscars Food Safety

Spanish Social Media

Kratom Salmonella Outbreak
Salmonella Chicken Salad Outbreak
Flu

Bring Your Brave Repost
HIV Testing
Less Stressful Shots
Whooping Cough- Pertussis Feature
Women and Heart Disease Feature
Genomics and Heart Disease Feature

Social Media Highlights

- On February 20th, Million Hearts announced the call for applications for the 2018 Hypertension Control Champions. POC: Lauren Elsberry

- The session of CDC Public Health Grand Rounds, "Million Hearts® 2022: A Compelling Call to Action", was held on Tuesday, February 20, 2017 at 1:00 pm ET. The session was live streamed on CDC's Facebook page www.facebook.com/cdc. POC: Michelle Walker

*The Web Features for CDC.gov will be determined per week.

Michelle Bonds
Director
Division of Public Affairs

CDC 24/7 Saving Lives. Protecting People.™

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 5 Apr 2018 16:49:15 +0000
To: McKeon, Richard (SAMHSA/CMHS);Pearson, Jane L (NIH/NIMH) [E];'John Draper'
Subject: **Request for your review: Suicide Vital Signs Fact Sheet
Attachments: Suicide Vital Signs Fact Sheet after roundtable to share 4.4.18.docx, opioid 2018-03-vitalsigns.pdf
Importance: High

Hi Richard, Jane, and John,
I hope you are doing well! As you are hopefully aware, CDC is releasing a Vital Signs on Suicide on June 5th. If you aren't familiar with *Vital Signs*, it began in 2010 and is a high profile monthly CDC publication widely distributed to highlight important public health threats and what can be done to prevent them. The release always includes a web page, an MMWR article, a translation piece (i.e. fact sheet), a press release, a telebriefing with the media by the CDC Director, a virtual town hall meeting, and other products. As you can imagine it's a lot of work! I am currently leading the effort but am assisted by many people.
I wanted to give you a heads-up about the content to make sure it strikes the right balance between highlighting the importance of mental health problems and the fact that many people don't have mental health problems so we need to address the range of risk and include a range of prev strategies. The MMWR and the fact sheet are currently in clearance but we have a small window to make revisions. I have permission to share the fact sheet and some brief pieces of the MiMWR.
Wondering if you can respond by Monday noon with any comments on the fact sheet and any tweaks to wording in text below if you think it's not in balance. Also note that certain details have been omitted (some of which are actually in the fact sheet).
A note on the fact sheet: This draft is the result of our first (3 hr meeting) with the vital signs team. We've been told the fact sheet goes through like 200 revisions?! Everything in the fact sheet must also be stated in the MMWR and it has to be plain language. The fact sheet is 4 pages and came with 14 pages of guidance if that tells you anything! Attaching the latest opioid one for your convenience.

MMWR Abstract

Contributing Circumstances to Suicide and Increasing Trends in State Suicide Rates
Deb Stone, Tom Simon, Katie Fowler, Scott Kegler, Keming Yuan, Kristin Holland, Asha Ivey-Stephenson, and Alex Crosby

Background: Suicide rates in the United States have risen nearly 30% since 1999. Mental health problems (MHP) are just one factor contributing to suicide. Examining state-level trends in, and the multiple contributing circumstances to, suicide can inform comprehensive state suicide prevention planning.

Methods: Trends in age-adjusted suicide rates among people aged ≥10 years, by state and sex, across six consecutive three-year periods (1999-2016), were assessed using data from the National Vital Statistics System for 50 states and Washington, D.C. Data from the National Violent Death Reporting System, covering 27 states in 2015, were used to examine contributing circumstances among decedents with and without known mental health problems (MHP).

Results: From 1999-2016, suicide rates increased significantly in 44 states, with 25 states experiencing increases of more than 30%...In 2015, more than half (54%) of decedents in 27 states did not have a known MHP. Among people with circumstance information, several circumstances, including relationship problems/loss (45.1% vs 39.6%), life stressors (54.2% vs 49.7%), and

recent/impending crises (32.9% vs 26.0%) were significantly more likely among those without a known MHP than decedents with MHP, but were common across groups.
Conclusions: Suicide rates increased significantly across most states from 1999-2016. Various circumstances contributed to suicides among people with and without known MHP.
Implications for Public Health Practice: States can use a comprehensive evidence-based public health approach to prevent suicide risk before it occurs, identify and support people at risk, prevent reattempts, and help friends/family after a suicide occurs.

Part of the Intro (Would like your thoughts on whether this is striking the right balance. This is my main reason for wanting your feedback. We want to make the case for a focus on the full range of factors impacting on suicide and the full range of prevention strategies without inadvertently sending the message that those other factors and other strategies aren't important. They definitely are. We need it all.

- The *National Strategy for Suicide Prevention(NSSP)*(5) calls for a public health approach to suicide prevention with efforts spanning across multiple levels (i.e., individual, family/relationship, community, and societal). Such an approach underscores that suicide is rarely caused by any single factor, but rather, is multi-determined.
- Despite the NSSP guidance, suicide prevention efforts are largely clinically-oriented, focused on treating mental health problems (MHP) and preventing re-attempts (6).
- Apart from MHP and prior attempts, other contributing circumstances to suicide include social and economic problems, access to lethal means (e.g., substances, firearms, bridges) among people at risk, and poor coping and problem-solving skills (5). Expanded awareness of these additional circumstances contributing to suicide risk and action to address them, can help reach the nation's goal of reducing suicide rates 20% by 2025 (7).

Part of the methods:

- Characteristics and circumstances of suicide decedents ≥10 years old, with and without known MHP, were compared in the 27 states with complete data participating in CDC's National Violent Death Reporting System (NVDRS) in 2015.
- NVDRS defines MHP as disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (9), with the exception of alcohol and other substance dependence, which are captured separately in NVDRS.

Part of the results: [Main point: while there were specific differences between the groups, the main point is that both groups had multiple circumstances and so we need to be addressing all of these in our prevention activities]

- People without known MHP were less likely to have any substance abuse problems
- …two-thirds of those with known MHP had a history of mental health or substance abuse treatment (67.2%), just over half (54.0%) were in current treatment.
- Decedents without, versus those with, known MHP, had significantly greater likelihood of any relationship problem/loss, specifically intimate partner problems, arguments... They also were more likely to have experienced any life stressors, such as criminal-legal problems, or eviction/loss of home and were more likely to have had a crisis within the preceding or upcoming two weeks. All of these differences remained significant in the adjusted models.
- Among all people with crises, intimate partner problems were the most common types and did not differ by group.
- Similarly, among people without versus with MHP, physical health problems and job/financial problems were commonly experienced and did not differ by group.

Part of the discussion:

- …Additional research into the specific causes of these trends is necessary. Fortunately, data from the 27 states participating in NVDRS provides important insight into suicide circumstances and can help states identify prevention priorities.
- …suicide prevention research and practice is heavily oriented towards downstream treatment of MHP and prevention of reattempts. Additional focus on non-mental health factors, further upstream, is essential to a public health approach (10), as the current study found that more than half of suicide decedents in NVDRS did *not* have a known MHP. ..
- …people with MHP also experienced other life stressors such as job/financial, relationship, and/or physical health problems. These findings point to the need to both prevent the conditions associated with mental health problems in the first place, and to support people with known MHP to decrease their risk of poor outcomes.
- Two-thirds of this group had a history of any mental health and/or substance abuse treatment, with over half in treatment when they died. This suggests the need for additional safety supports, including broader implementation of affordable and effective treatment modalities such as doctor-patient collaborative care models and proven cognitive-behavioral therapies. Additionally, greater access to behavioral health providers in underserved areas is needed, as is expansion of healthcare systems needed that integrates physical and behavioral health with a priority on suicide prevention and patient safety, especially through care transitions (12).
- Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide…[insert technical package components here]
- Limitation--abstractors of NVDRS data are limited to information contained in investigative reports. Therefore, the extent of informant knowledge can impact data completeness and accuracy. Studies including more in-depth interviews with next-of-kin often see greater attributions to mental disorders.

Rising suicide rates across states

More than just a mental health problem

45,000

Nearly 45,000 suicides in 2016

30%

Suicide rates increased more than 30% in half of states in the US

50%

More than half of people who died by suicide did not have a known mental health problem

Suicide is a leading cause of death in the US and has greatly increased in 44 states (1999-2016). Mental health problems are often seen as the sole cause, but suicide is rarely caused by a single factor. Many people who die by suicide are not known to have mental health problems at the time of death. Other issues also contribute to suicide, including failing relationships, poor health, job stress or unemployment, money, housing, and legal problems. Close coordination of civic, law enforcement, business, education, social services, faith, media, and health sectors is important for preventing suicide. States and communities can take actions now based on the best available evidence. State public health departments can be the leaders in bringing together the necessary community partners for action.

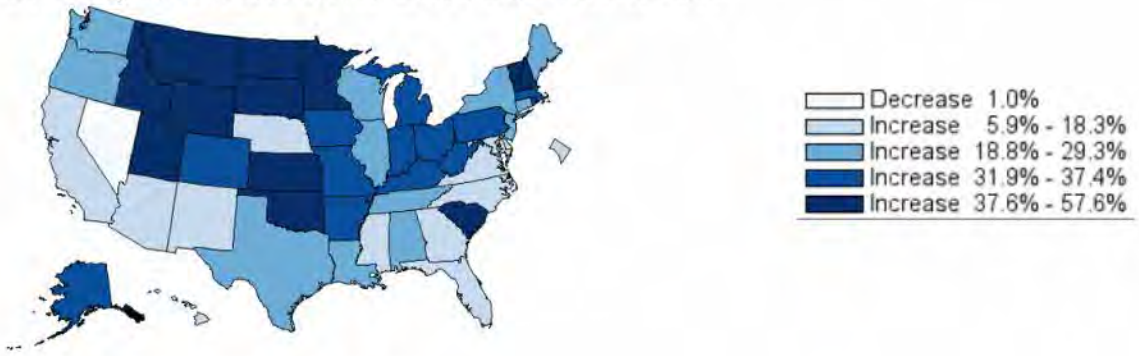
States and communities can:

- Identify and support people at risk of suicide.
- Lessen harms and prevent future risk of suicide.
- Teach coping and problem-solving skills to help youth and adults manage everyday challenges.
- Create safe and supportive environments where people live, work, learn, and play.
- Make sure people are connected to others in their community and don't feel alone.
- Make sure those at risk are connected to healthcare systems that include mental and physical health.
- Strengthen temporary financial and housing assistance for those struggling to make ends meet.

[INCLUDE LINK TO TECHNICAL PACKAGE:
www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf]

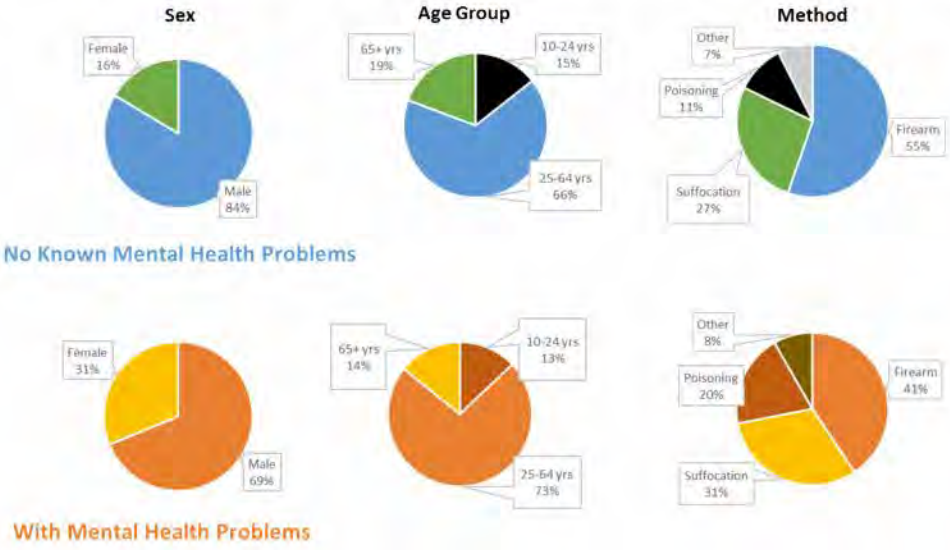
Problem: State suicide rate increases ranged from 6% to 58%

Deaths by suicide rose across the US from 1999 to 2016



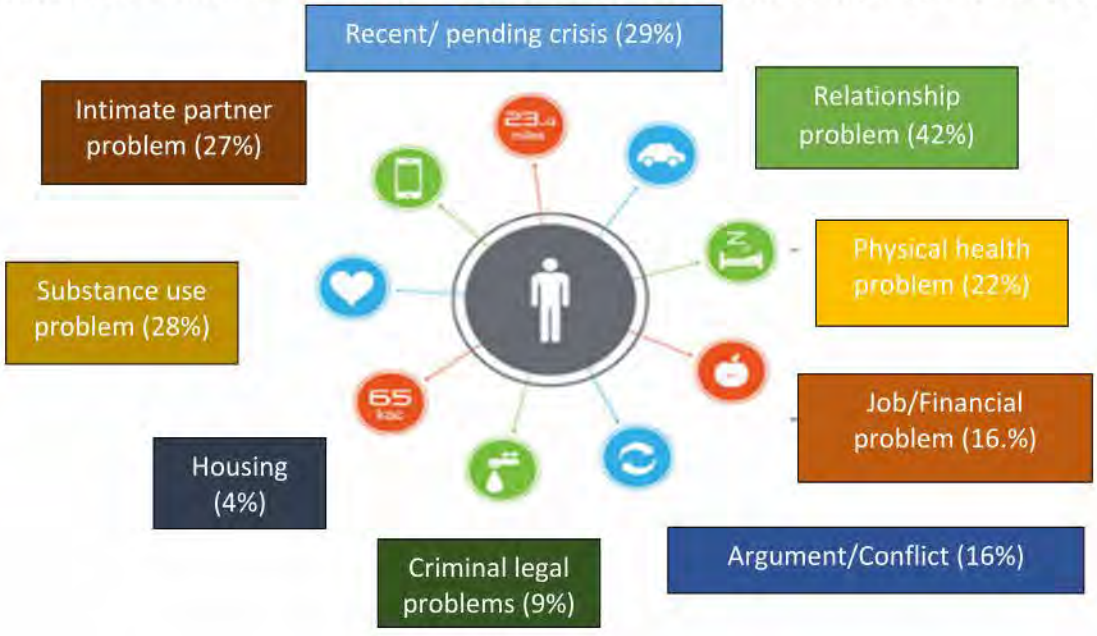
Many factors contribute to suicide

- 54% of people who died by suicide did not have a known mental health problem.



- Many factors contribute to suicide among those with and without mental health problems.

[Note: Icons below will be changed to reflect the problem listed. This is just to convey the idea]



States are seeing increases. What can they do prevent suicides?

Use *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* to make decisions based on the best evidence for suicide prevention **[This could be in a banner going across the page with the link to the technical package www.cdc.gov/violenceprevention/pub/technical-packages.html]**



[Create an infographic like the one below that lists warning signs. It will be updated to reflect the latest guidance on warning signs]



WHAT CAN BE DONE



The Federal government is:

- Tracking and monitoring the problem.
- Sharing information on actions proven to prevent suicide.
- Working with other local, state, and federal governmental agencies to prevent suicide.

States and communities can:

- Identify and support people at risk of suicide.
- Lessen harms and prevent future risk of suicide.
- Teach coping and problem-solving skills to help youth and adults manage everyday challenges.
- Create safe and supportive environments where people live, work, learn, and play.
- Make sure people are connected to others in their community and don't feel alone.
- Make sure those at risk are connected to healthcare systems that include mental and physical health.
- Strengthen temporary financial and housing assistance for those struggling to make ends meet.

Healthcare systems can

- Make sure entire healthcare systems provide high quality, ongoing care, focusing on suicide prevention.
- Make sure healthcare is easily accessible and provide options such as telecommunications in areas where services aren't available.
- Provide personalized, proven treatment plans for patients at risk of suicide.

Employers can:

- Promote employee health and well-being, support people at risk, and have plans in place to respond to risk effectively.
- Train all employees about suicide risk and prevention.
- Encourage employees to seek help and provide referrals to mental health, substance abuse, or financial counseling services as needed.

Everyone can:

- Reduce access to lethal means, such as medications and firerams, among people at risk.
- Learn the warning signs of suicide to help identify and refer people at risk.
- Contact the National Suicide Prevention Lifeline for help for themselves or others: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org/

[Call out box: The media can encourage help-seeking and avoid dramatic headlines using guidelines at www.ReportingOnSuicide.org]

#vitalsigns
MAR 2018

CDC Vitalsigns™

↑30% Opioid overdoses went up 30% from July 2016 through September 2017 in 52 areas in 45 states.

↑70% The Midwestern region saw opioid overdoses increase 70% from July 2016 through September 2017.

↑54% Opioid overdoses in large cities increased by 54% in 16 states.



Want to learn more?
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Opioid Overdoses Treated in Emergency Departments

Identify opportunities for action

Emergency department (ED) visits for opioid* overdoses rose 30% in all parts of the US from July 2016 through September 2017. People who have had an overdose are more likely to have another, so being seen in the ED is an opportunity for action. Repeat overdoses may be prevented with medication-assisted treatment (MAT) for opioid use disorder (OUD), which is defined as a problematic pattern of opioid use. EDs can provide naloxone, link patients to treatment and referral services, and provide health departments with critical data on overdoses. ED data provide an early warning system for health departments to identify increases in opioid overdoses more quickly and coordinate response efforts. This fast-moving epidemic does not stay within state and county lines. Coordinated action between EDs, health departments, mental health and treatment providers, community-based organizations, and law enforcement can prevent opioid overdose and death.

Health departments can

- Alert communities to rapid increases in overdoses seen in EDs for an informed and timely response.
- Increase naloxone distribution (an overdose-reversing drug) to first responders, family and friends, and other community members in affected areas, as policies permit.
- Increase availability of and access to treatment services, including mental health services and MAT for OUD.
- Support programs which reduce harms from injecting opioids, including those offering screening for HIV and hepatitis B and C, in combination with referral to treatment.
- Support the use of the *CDC Guideline for Prescribing Opioids for Chronic Pain*, which encourages using prescription drug monitoring programs (PDMPs) to inform clinical practice. https://go.usa.gov/xn6uQ

*Opioids include prescription pain medications, heroin, and illicitly manufactured fentanyl.

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National Center for Injury Prevention and Control



PROBLEM:

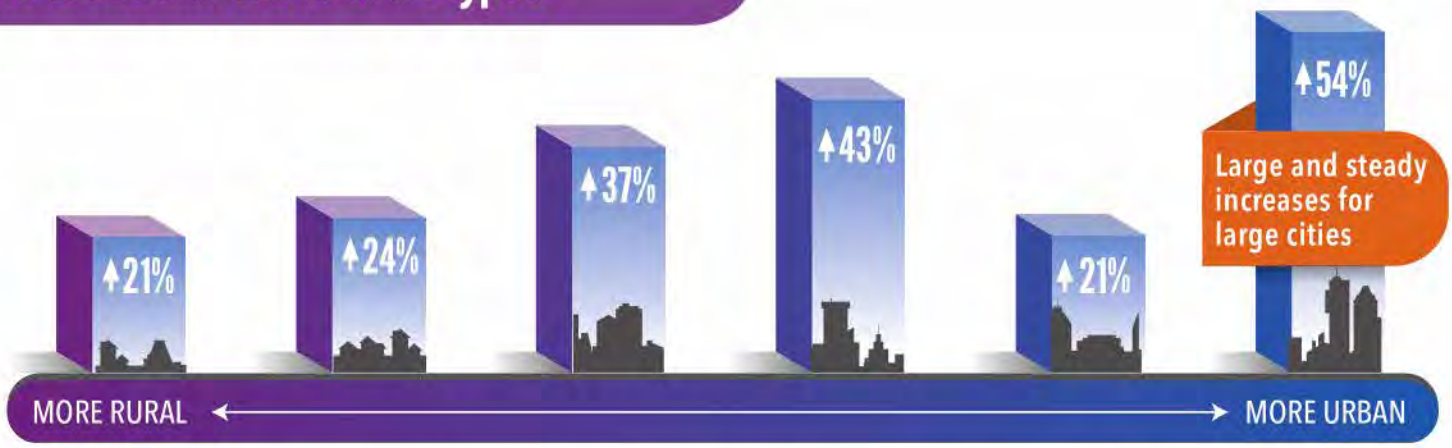
Opioid overdose ED visits continued to rise from 2016 to 2017.

From July 2016 through September 2017, opioid overdoses increased for:

- Men (↑30%) and women (↑24%)
- People ages 25-34 (↑31%), 35-54 (↑36%), and 55 and over (↑32%)
- Most states (↑30% average), especially in the Midwest (↑70% average)

SOURCE: CDC's National Syndromic Surveillance Program, 52 jurisdictions in 45 states reporting.

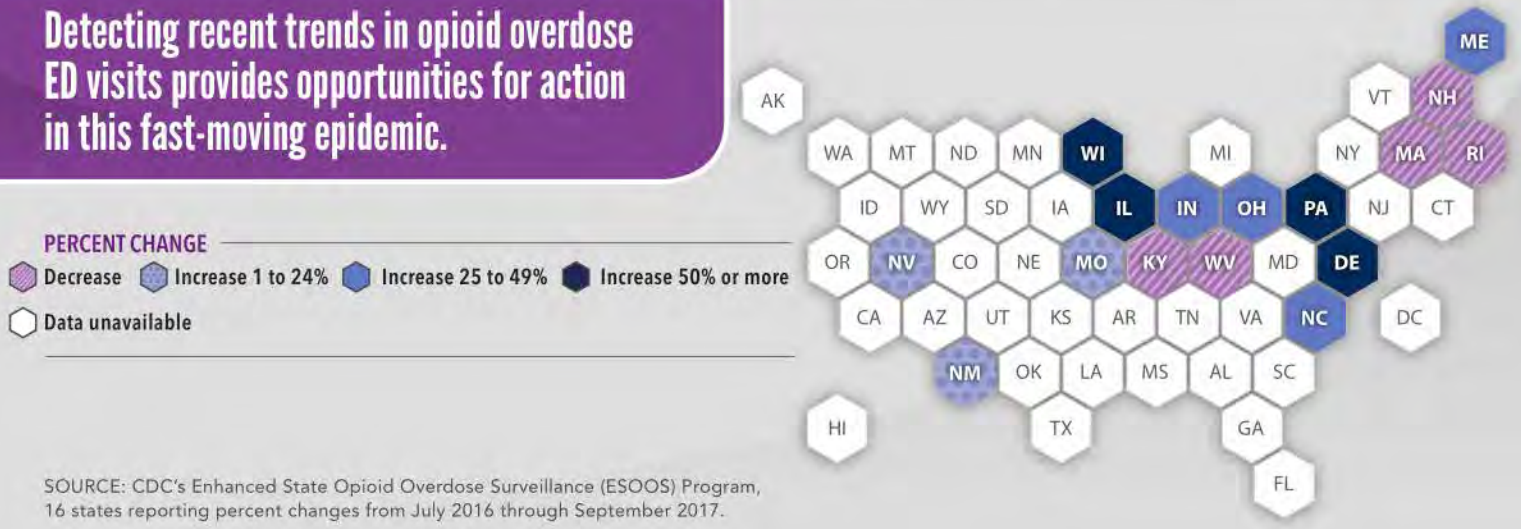
Opioid overdoses continued to increase in cities and towns of all types.*



SOURCE: CDC's Enhanced State Opioid Overdose Surveillance (ESOOS) Program, 16 states reporting percent changes from July 2016 through September 2017.

* From left to right, the categories are:
1) non-core (non-metro), 2) micropolitan (non-metro), 3) small metro, 4) medium metro, 5) large fringe metro, 6) large central metro.

Detecting recent trends in opioid overdose ED visits provides opportunities for action in this fast-moving epidemic.



SOURCE: CDC's Enhanced State Opioid Overdose Surveillance (ESOOS) Program, 16 states reporting percent changes from July 2016 through September 2017.

A rise in opioid overdoses is detected. What now?

Naloxone is a drug that can reverse the effects of opioid overdose and can be life-saving if administered in time.

Medication-assisted treatment (MAT) for opioid use disorder (OUD) can aid in preventing repeat overdoses. MAT combines the use of medication (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

Local Emergency Department



- Offer naloxone and training to patient's family and friends, in case the patient has another overdose.
- Connect patients with hospital case managers or peer navigators to link them to follow-up treatment and services.
- Plan for the increasing number of patients with opioid-related conditions, including overdose, injection-related concerns, and withdrawal.

First Responders | Public Safety | Law Enforcement Officers



- Get adequate supply and training for naloxone administration.
- Identify changes in illicit drug supply and work with state and local health departments to respond effectively.
- Collaborate with public health departments and health systems to enhance linkage to treatment and services.

Mental Health and Substance Abuse Treatment Providers



- Increase treatment services, including MAT for OUD.
- Increase and coordinate mental health services for conditions that often occur with OUD.

Coordinated, informed efforts can better prevent opioid overdoses and deaths

Community Members



- Connect with organizations in the community that provide public health services, treatment, counseling, and naloxone distribution.

Community-Based Organizations



- Assist in mobilizing a community response to those most at risk.
- Provide resources to reduce harms that can occur when injecting drugs, including ones that offer screening for HIV and hepatitis B and C, in combination with referral to treatment and naloxone provision.

Local Health Departments



- Alert the community to the rapid increase in opioid overdoses seen in emergency departments and inform strategic plans and timely responses.
- Ensure an adequate naloxone supply.
- Increase availability and access to necessary services.
- Coordinate with key community groups to detect and respond to any changes in illicit drug use.

SOURCE: CDC Vital Signs, March 2018.

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS

- Tracking overdose trends to better understand and more quickly respond to the opioid overdose epidemic.
- Improving access to OUD treatment, such as MAT, and overdose-reversing drugs, such as naloxone.
- Educating healthcare providers and the public about OUD and opioid overdose, and providing guidance on safe and effective pain management.
- Equipping states with resources to implement and evaluate safe prescribing practices.
- Coordinating actions to reduce production and impacts of the illicit opioid supply in the US through the High Intensity Drug Trafficking Areas (HIDTA) Program.
- Supporting cutting-edge research to improve pain management and OUD treatment.

HEALTH DEPARTMENTS CAN

- Alert communities to rapid increases in overdoses seen in EDs for an informed and timely response.
- Increase naloxone distribution (an overdose-reversing drug) to first responders, family and friends, and other community members in affected areas, as policies permit.
- Increase availability of and access to treatment services, including mental health services and MAT for OUD.
- Support programs that reduce harms which can occur when injecting opioids, including those offering screening for HIV and hepatitis B and C, in combination with referral to treatment.
- Support the use of the *CDC Guideline for Prescribing Opioids for Chronic Pain*, which encourages using prescription drug monitoring programs (PDMPs) to inform clinical practice. https://go.usa.gov/xn6uQ

EMERGENCY DEPARTMENTS CAN

- Develop post-opioid overdose protocols, which may include
  - Offering overdose prevention education, naloxone, and related training for patients, family members, and friends.
  - Linking patients to treatment and services in the community as needed.
  - Starting MAT in the ED.

HEALTHCARE PROVIDERS CAN

- Prescribe opioids only when benefits are likely to outweigh risks.
- Determine a patient's prescription drug history and level of risk by accessing data from their state PDMP.
- Identify mental health, social services, and treatment options to provide appropriate care for patients who have OUD.
- Follow the *CDC Guideline for Prescribing Opioids for Chronic Pain*. https://go.usa.gov/xn6uQ

EVERYONE CAN

- Learn about the risks of opioids. https://go.usa.gov/xn6um
- Learn about naloxone, its availability, and how to use it. https://go.usa.gov/xn6uV
- Store prescription opioids in a secure place, out of reach of others (including children, family, friends, and visitors).
- Contact SAMHSA's National Helpline: 1-800-662-HELP for anyone who has trouble with opioid use. https://go.usa.gov/xn6uw

www.cdc.gov/vitalsigns
www.cdc.gov/vitalsigns/opioid-overdoses/

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov

Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Publication date: March 6, 2018

CS287946-A

From: Stone, Deborah (CDC/ONDIEH/NCIPC)
Sent: 25 Apr 2018 04:14:57 +0000
To: Simon, Thomas (CDC/ONDIEH/NCIPC);Fowler, Katherine A. (CDC/ONDIEH/NCIPC);Yuan, Keming (CDC/ONDIEH/NCIPC);Kegler, Scott R. (CDC/ONDIEH/NCIPC);Ivey-Stephenson, Asha Z. (CDC/ONDIEH/NCIPC);Crosby, Alexander (CDC/ONDIEH/NCIPC);Holland, Kristin (CDC/ONDIEH/NCIPC);Ballman, Marie R. (CDC/ONDIEH/NCIPC);Richmond-Crum, Malia (CDC/ONDIEH/NCIPC);Black, Erin (CDC/ONDIEH/NCIPC);Kurnit, Molly Regina (CDC/ONDIEH/NCIPC);Bruce, Crystal (CDC/OPHPR/OD)
Cc: Bartholow, Brad (CDC/ONDIEH/NCIPC);Herbst, Jeffrey (CDC/ONDIEH/NCIPC)
Subject: **VS Updates**
Attachments: 18_292322-A_Sokler_June_2018_Suicide_v2_04.23.18_LS_graphics to pgm.pdf

Hi Everyone,
Since we didn't have a meeting last week or this week (yikes!) and our next meeting isn't until next Tuesday, I wanted to take the time to provide some updates to keep everyone in the loop (apologies for the delay on this). I invite anyone to add to this update in case I've forgotten anything, which I'm so sure I have.
One REQUEST: By next week it would be great if the three task groups (MMWR, Fact Sheet, Comm/Policy) can update their to-do lists through May 15th. I don't have any specific guidance since it's late but will be good to keep ourselves organized and no what's coming next (mostly I'm suggesting this for myself probably!).
Where things stand currently:

- The **MMWR** was routed through clearance and cross-clearance successfully. It will be submitted to the MMWR office today.
- The **Fact sheet** team led heroically by Tom and aided by Crystal, Kristin, Asha, and myself has come a long way! Thank you to everyone who reviewed the latest version of the FS. Tom will submit the FS back to the VS team COB.
    - One sticking point right now is finding two good photos to include! This is no small task. The first photo is on page 1 and is next to the 'states and communities can: [insert 7 strategies]. Here some are thinking a group of people would be good to suggest organizing, collaboration, and connectedness. However, it really needs to convey the problem of suicide somehow. The second picture is placed right next to the heading on page 2 about the percentage change in rate increases. This is not a happy message of course so what do we place there? Trying to avoid depressed looking people. I personally am also trying to avoid pictures of women and teenagers so we represent the population with the highest burden, men. Molly and Crystal are helping with this conundrum. Attaching latest mock-up of FS.
    - Also, Molly now has the native files of the Bethe1to campaign image in her hands (yay!). Please see attached for what I'm talking about. The folks at Mental Health America are thrilled that their campaign will be featured.
- The **Comm team** has been extremely busy drafting the critical contacts email, the telebriefing script, the press release, and the dear colleague letter. These documents were routed from Crystal to Marie, myself, Malia, Tom, and will be reviewed in the next day by Leslie. These items are due to the VS office this Friday, April 27th. I'm working on some FAQs today to include with the telebriefing script.
- Re **Partnerships**, Dr. Schuchat mentioned the VS at the Action Alliance Executive Committee meeting a few weeks ago, and Robin Ikeda mentioned the VS at the American Association of

Suicidology meeting last week. Kristin also mentioned the VS to the Data and Surveillance Task Force of the Action Alliance, and she and I met with Colleen Carr and Farrah Kaufmann also of the Action Alliance. Kimberly Torguson of the Action Alliance's Media workgroup has been alerted as have Federal Partners on our monthly call. **It was recommended that we reach out to the National Council for Suicide Prevention if we haven't already done so. An update re the Surgeon General's participation is forthcoming (Feel free to update here).

- The medical outreach call with Brandy Peaker occurred this past Monday. This was a productive meeting. **Feel free to update here.
- The **pre-briefing** with Dr. Schuchat has been scheduled and rescheduled multiple times. It's currently on May 7th from 1-1:45. In addition, to accommodate Dr. Schuchat's travel schedule the VS has been pushed back until **JUNE 7th.**
- **NCHS data brief** on suicide will be delayed until after our VS comes out. That was very generous of them. Thanks to Tom for working that out!
- One piece of bad news, the **AJPH commentary** was rejected ☹ I will assess whether it makes sense to try JAMA or AJPM (i.e. whether content is appropriate and whether timing is at all possible—guessing no on both fronts). The next idea is to have a commentary come out after the VS in another journal.
- Other items—I'm sure I'm forgetting or don't know about many things so please add here!

That's all for now. Sorry for the overly long email. Please let me know if you have any questions or concerns. Thanks a million to everyone for the great work. We've really made great strides thus far! Six week to go. Go Team! ☺

Deb

Deb Stone, ScD, MSW, MPH
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention
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770.488.3942
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VS_v3_4/23/18_3 P.M.

#vitalsigns
JUN. 2018

CDC Vitalsigns™

45K Nearly 45,000 suicides in 2016.

30% Suicide rates increased more than 30% in half of US states since 1999

50% More than half of people who died by suicide did not have a known mental health problem

Photo placeholder

Rising suicide rates across states

More than a mental health problem

Suicide is a leading cause of death in the US and has increased in 44 states (1999-2016). Mental health problems are often seen as the sole cause, but suicide is rarely caused by a single factor. Many people who die by suicide are not known to have mental health problems at the time of death. For those with or without mental health problems, other issues can contribute to suicide, including relationship problems, poor health, unemployment, legal problems, substance abuse or stress about a job, money, or housing. There are opportunities for prevention every day. Close coordination of health, law enforcement, business, education, social services, faith, and media sectors is important for preventing suicide. States and communities can take actions now based on the best available evidence. State public health departments can be leaders in bringing together the necessary community partners and guiding action.

States and communities can:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help youth and adults manage challenges with relationships, jobs, health, or other concerns.
- Create safe and supportive environments where people live, learn, work, and play.
- Make sure people are connected to others in their community and don't feel alone.
- Make sure those at risk are connected to health systems that include mental and physical healthcare.
- Strengthen options for temporary assistance for those struggling to make ends meet.
- Lessen harms and prevent future risk of suicide.

Want to learn more?
Visit: www.cdc.gov/vitalsigns

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National Center for Injury Prevention and Control

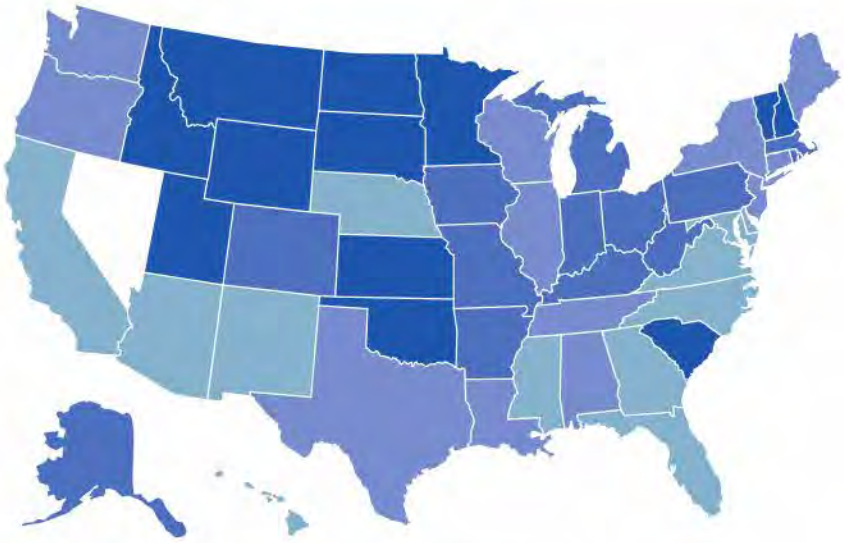
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PROBLEM:

State suicide rate increases ranged from 6% to 58%

Suicide rates rose across the US from 1999 to 2016

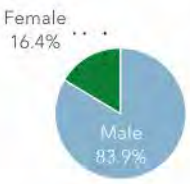
- Decrease 1%
- Increase 6% - 18%
- Increase 19% - 29%
- Increase 32% - 37%
- Increase 38% - 58%



Differences exist in those with and without mental health problems

No Known Mental Health Problems

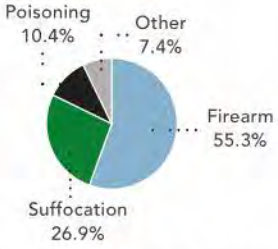
Sex



Age Group

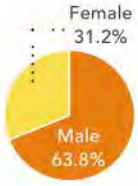


Method

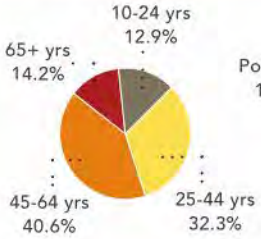


With Mental Health Problems

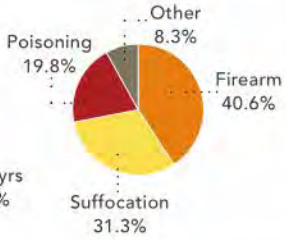
Sex



Age Group

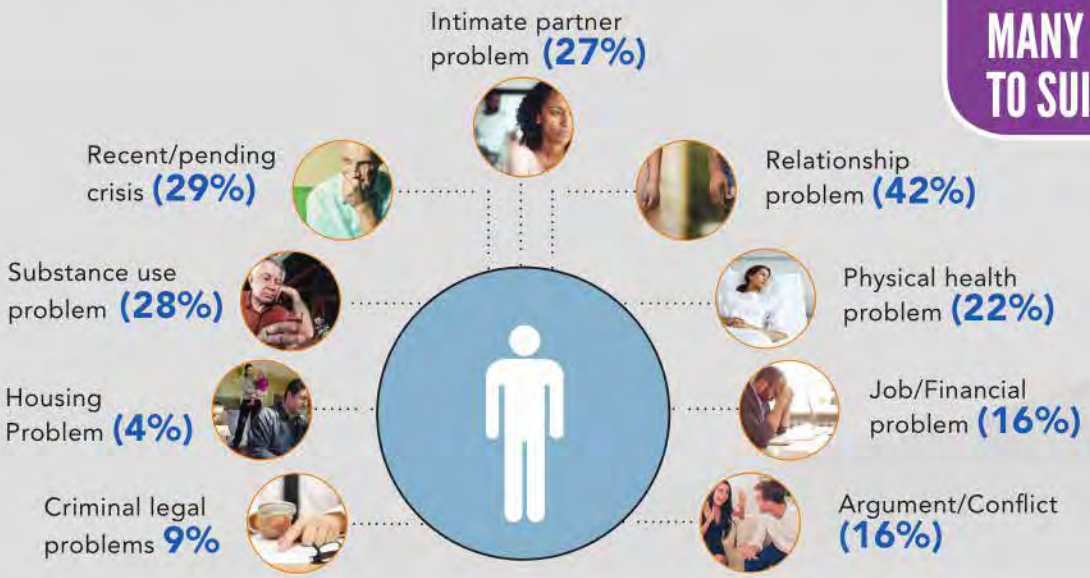


Method



- 54% of people who died by suicide did not have a known mental health problem.
- Other factors can play a role among those with or without mental health problems.

MANY FACTORS CONTRIBUTE TO SUICIDE



SOURCE: pending.

STATES ARE SEEING INCREASES. WHAT CAN THEY DO TO PREVENT SUICIDES?

Use *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* to guide actions based on what is known about keeping people safe
www.cdc.gov/violenceprevention/pub/technical-packages.html

- States can make sure mental health care is affordable and easy to access so people in need don't "fall through the cracks."

  Providers can make treatment available by phone or online where services are not widely available.

- States can help ease unemployment and housing stress through temporary financial and housing assistance.

- Everyone can reduce access to lethal means among people at risk by safely storing medications and firearms.

  Employers can put in place policies that create a healthy environment and reduce stigma about seeking help.

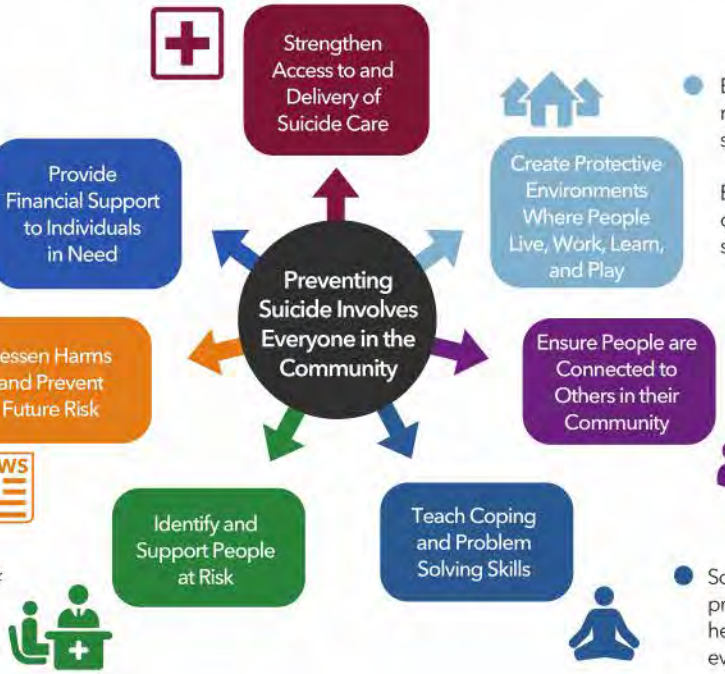
- Communities can provide supportive resources to friends/family after a suicide.

  Media can report on suicide in ways don't increase risk and link to helping resources.

- Communities can provide activities that help people stay connected so they don't feel alone or become isolated.

- Everyone can learn the signs of suicide, how best to respond, and where to access help.

- Schools can teach coping and problem- solving skills that help young people tackle every day problems.





SOURCE: CDC Vital Signs, Month, Year.

WHAT CAN BE DONE

THE FEDERAL GOVERNMENT IS:

- Tracking the problem to understand trends and the groups at greatest risk (for example see https://www.cdc.gov/violenceprevention/nvdrs/index.html).
- Developing, implementing, and evaluating suicide prevention strategies
- Working with local, state, tribal, and other partners to prevent suicide.

STATES AND COMMUNITIES CAN:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help youth and adults manage challenges with relationships, jobs, health, or other concerns.
- Create safe and supportive environments where people live, learn, work, and play.
- Make sure people are connected to others in their community and don't feel alone.
- Make sure those at risk are connected to health systems that include mental and physical healthcare.
- Strengthen options for temporary assistance for those struggling to make ends meet.
- Lessen harms and prevent future risk of suicide.

HEALTH CARE SYSTEMS CAN:

- Make sure entire healthcare systems provide high quality, ongoing care, focusing on suicide prevention.
- Make sure healthcare is easily accessible and provide options by phone or online in areas where services aren't available.
- Provide personalized, proven treatment options for patients at risk of suicide.

EMPLOYERS CAN:

- Promote employee health and well-being, support people at risk, and have plans in place to respond to risk effectively.
- Train all employees about suicide risk and prevention.
- Encourage employees to seek help and provide referrals to mental health, substance abuse, or financial counseling services as needed.

EVERYONE CAN:

- Reduce access to lethal means, such as medications and firearms, among people at risk.
- Learn the warning signs of suicide to help identify and refer people at risk.
- Contact the National Suicide Prevention Lifeline for help for themselves or others: 1-800-273-TALK (8255). https://suicidepreventionlifeline.org/



www.cdc.gov/vitalsigns/suicide
www.cdc.gov/mmwr

For more information, please contact
Telephone: 1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 | Web: www.cdc.gov

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